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GROUP PSYCHOTHERAPY AS AN AID TO OUT-PATIENT TREATMENT IN A PSYCHIATRIC CLINIC*

BY LOUIS WENDER, M. D.,** AND AARON STEIN, M. D.†

This report deals with experiences encountered over a period of one year with the use of group psychotherapy on an out-patient basis. During this time an opportunity was afforded to note the effectiveness of group psychotherapy with out-patients and to observe some of the dynamic factors involved.

All the patients who participated in the group psychotherapeutic sessions also received individual psychotherapy. The decision to use group psychotherapy with out-patients was made because it was felt these patients needed more treatment. Because of the large number of patients in the clinic and the limited number of psychiatrists available, patients could be seen at best only once a week, and many came less frequently. This was obviously insufficient time for successful individual psychotherapy.

Past experience[1, 2, 3] with this form of group psychotherapy had shown that it encouraged patients to express themselves and that it stimulated the production of significant material from the unconscious. It aided in the release of tensions and the development of transference. For these reasons it was felt that group psychotherapy could be effective not only *per se* but that it could also supplement and facilitate individual psychotherapy. The method used here differs from that used by Schilder with out-patients.[2] The present technique followed the technique previously described by one of the writers.[1]

Description of Method

The group psychotherapeutic sessions were held once a week in the evening. Each lasted one hour. The meetings were in a conference room adjacent to the psychiatric clinic from which the patients were referred, and the sessions were conducted in a very informal fashion. Smoking was permitted, the patients could sit wherever they pleased, could ask questions of the therapist or of other patients, make comments, etc. They were referred to the

*Read before the 104th annual meeting of the American Psychiatric Association, Washington, D. C., May 17-20, 1948.

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group sessions by the psychiatrists who were giving them individual treatment. The aim and the method of the group sessions had been described at a conference with the psychiatrists comprising the staff of the clinic. The only limitations imposed as to the kind of patients who might be referred for group therapy were that the patients should be capable of understanding and should be fairly communicative. Except for these limitations, the patients were unselected. New ones were introduced into the group at various times.

Before being admitted to the sessions, each patient was interviewed by the group therapist. During this interview, the therapist familiarized himself with the nature of the patient's problem and obtained some background material. This information provided specific points that could be taken up in the group sessions. The interview also served to familiarize the patient with the therapist and made the former's introduction to the group less difficut.

No formal scheme was followed in conducting the sessions. The primary aim was to have the patients express themselves; there were no "lectures" as such. However, in the first few sessions, in order to orient the patients and to "warm up" the group, the therapist made a few introductory remarks, simply and briefly. He explained the purpose of the sessions and indicated how the patients could help one another understand and work out their problems. Then he made a few remarks on the nature of illness in general, explaining cause and effect and leading up to the similar mechanisms, namely, the underlying emotional conflict and its results that are involved in neurotic illness. There were illustrations from everyday life and, without using names, from the histories of the patients in the group. This was made possible by the therapist's knowledge of the patients gained during the initial interviews.

By beginning in this comparatively impersonal fashion, while specifically directing the introductory remarks to the patients' own problems, the necessary stimulation for participation in the group discussion was provided. The patients then asked questions and this provided a relatively easy way for them to begin to speak up in the group sessions. Many questions were usually forthcoming, ranging from those relating to symptoms to more general ones.

The subsequent sessions were conducted very much as is done in individual psychoanalytic psychotherapy. The method was very similar to the one used in that form of treatment, with the very im-

portant addition of the participation of the members of the group. The chief function of the therapist was to help the patients express themselves. What was aimed at was that they should bring up material concerning themselves and that other patients should comment about this. The patients themselves, under the guidance of the therapist, would analyze, interpret and point out the underlying mechanisms and unconscious factors. Frequently such discussions occurred spontaneously. At other times, by appropriate questions, the therapist would help to initiate such a discussion. Rarely, the therapist would have to guide the discussions away from a trend which was likely to be disturbing to a patient or the group.

In guiding these discussions, the therapist, because of his knowledge of each patient's problem, has a unique opportunity to direct the discussion of specific points toward patients who would benefit most by discussing them. This latter is the technique of utilizing the group discussions and the group relationships to help overcome resistance and to facilitate the patients' understanding and acceptance of their particular difficulties.

An illustration from one of the group sessions shows how this is done:

A rather passive man of 34, who was closely attached to his mother and who had a probable latent homosexual attachment to his younger brother, opened one of the sessions by asking "why little things can get you down." He had been married three years and then had become depressed because he felt he no longer loved his wife. The reasons he felt he didn't love her might seem trivial but they were important to him. These were that she had hair on her face and big thighs. The therapist asked one of the women patients what she thought of this. She said he must have known these things before he married his wife. Others joined in the discussion and through friendly questioning of the patient tried to find out if he had other reasons for not caring for his wife.

During the course of this, the patient's basic personality defects were brought out—that he was attached to his brother and married only because the brother did, that he never entered wholeheartedly into the marriage, disliked the responsibility, financial and otherwise, of the marriage, and that throughout he remained closely attached to his mother. Then the therapist asked another man, whose problem was somewhat similar to the first patient's, that is, close attachment to his mother and to a brother, to com-

ment on what the other patient had said. The second patient began by asking the first one how his brother had felt about the marriage. In the discussion that followed, under the guidance of the therapist, the attachment to the mother and the brother in the case of the first patient was emphasized. The second patient then began to defend the first one, explaining that there was nothing wrong in caring for your mother or in brothers liking each other's company. If brothers went out together on dates, they could help each other out. In doing this, he, of course, revealed his own dependence on his mother and his attachment to his brother as well as his fear of heterosexual relationships. The therapist, by appropriate comments, made this latter fear clear to him.

After some hesitation, the second patient agreed and said, yes, he guessed he was rather bashful with girls. Asked for details he gave an account of a date in which he had spent until 5:00 a. m. talking to a girl who rather obviously was inviting lovemaking. The therapist then asked the first patient what he thought of this and the latter promptly replied that this clearly showed the other man was afraid of women, "I guess like I am." The therapist closed the session by pointing out in everyday language, how, in the case of both men, their dependence and their attachments to mother and brother revealed their emotional immaturity and led to their fear of adult, heterosexual relationships.

As the illustration shows, the resistance that is always present is minimized by the feeling of each patient that others' problems, not his own, will be discussed. The patient does not censor his own thoughts in discussing the others' problems. Once he enters into a discussion, he spontaneously—through identification with the other patients as will be described later—overcomes his resistance and speaks of his own difficulties, being unaware that he is doing so and that he is disclosing material that he might otherwise not divulge. The therapist, watchful for such productions, is able to emphasize them in the discussions. Then he asks other patients with similar problems to comment on these significant remarks, and the whole process is continued. In this way, under the guidance of the therapist, patients can specifically help each other to release unconscious material without great emotional traumatization.

Putting this another way, it might be said that the patients in the group, under the guidance of a group leader (the therapist),

function as would the therapist in psychoanalytic psychotherapy, except that the approach is indirect. In general the method is the same; it attempts, by making unconscious emotional conflicts clear, to alleviate maladjustments. But instead of there being only one patient and one therapist, there are many patients and many therapists. Instead of there being a relatively private or secret atmosphere for the therapeutic discussions, there is a much more open one. Finally the group as such and the role of the therapist as a group leader add factors that are entirely new to the therapeutic situation.

These differences from individual therapy, of course create new relationships which are the important factors in the treatment. An attempt will be made to describe these as they occurred with the group under discussion.

Dynamic Factors Observed in Group Psychotherapy

To understand what produces relief in the group therapy patients, one must know the problems of the patient coming to the clinic. Such an individual is functioning inadequately with many symptoms caused by emotional conflicts which he has not been able to solve. Thus a neurosis is precipitated, so that his libido is introverted and his narcissistic ego is hurt, producing many subjective symptoms.

Past experience with group psychotherapy[1, 2, 3] has clearly indicated that the emotional or libidinal ties between the members of the group themselves and between them and the therapist are the essential dynamic forces in the treatment. The manner in which these relationships develop is of significance. The patients who constituted this group were quite unknown to each other, came from varied backgrounds and lived in different circumstances. However, from the very first meeting of the group, they discovered, spontaneously and through the comments of the therapist, that they had certain important things in common with each other. These were: first, the nature of their illnesses and, second, their need for help.

The discovery that they all had a similar sort of illness was aided by the therapist's introductory remarks and, of course, at once provided some sort of a link between them. As will be pointed out later, this became the basis for the formation of an important emotional bond among the patients.

However, during the early sessions it was largely the patients' need for help that was their major tie to the group, and because of this the therapist was the focal point for their interest in the group. This resulted in the rather prompt establishment of the first emotional relationship in the group, that between the patients and the therapist. The writers have called this the patient-to-therapist transference. It resembles "object-cathexis of the anaclitic type" in that it is the establishment of an emotional tie to someone who, like the parent, fulfills certain needs. The relationship in the group is difficult to demonstrate. As in individual therapy, it was shown largely by the patients' attitudes rather than by their comments. However, in discussing later developments in the group relationship, more evidence for the transference to the therapist will be seen.

The sharing of the attachment to the therapist, together with the knowledge that they all had a similar type of illness, aided in the development of the next important relationship, that between the patients themselves. This was on the basis of identification through having the same sort of difficulties. The new bond between the patients, based on this identification, might be designated as patient-to-patient transference. Freud has pointed out the importance of this type of identification, particularly in relation to the formation of libidinal ties in groups. "Identification may arise with every new perception of a common quality shared with some other person who is not an object of the sexual instinct. The more important this common quality is, the more successful this partial identification may become and it may thus complete the beginning of a new tie."[4]

Innumerable examples of this identification of the patients with one another could be given. They ranged from patients having similar symptoms to more important identifications—as shown in the illustration from the group session that was given previously—such as their having similar attitudes and conflicts or similar early childhood experiences.

The discovery of similar feelings and attitudes in other patients served to lessen each patient's sense of isolation. It enabled them to share their sense of guilt—the largely unconscious guilt arising from the intensified but "forbidden" instinctual drives underlying their symptoms. As one woman said after hearing another patient discuss his feeling about sex, "I like the way he spoke; he seems

improved. I seem to have some guilty feelings about sex too. Although I am shamed, I would like to talk about it."

As a result of the emotional ties already noted—the patient-to-therapist transference and the patient-to-patient identification—these relationships were crystallized into a group-formation, and a unit with an identity and characteristics of its own resulted. This development could best be described by saying that the group had assumed the characteristics of a family—with the therapist as the central or father figure and the patients as the children or the siblings. This new relationship is clearly shown when a new patient is introduced into the group. Care must be taken not to pay too much attention to him or to discuss his case too much in detail at first. Unless this is done, what might be called sibling rivalry will develop, and the other patients will clearly show their resentment at the attention paid to the new-comer. As one patient said, "I don't like it when a new patient's case is discussed too much. It doesn't give me a chance to talk."

As has been pointed out previously[1, 2] when this new group-formation has occurred it becomes the most important factor in the therapy. Through it, in an indirect fashion which is therefore more acceptable, the thwarted instinctive tendencies the patient originally directed toward his own family can be channeled, and infantile fixations and regressions can be worked out. What has been called "catharsis in the family" occurs. "The patient finds himself sitting on terms of equality with the therapist (symbolic of the parent or as Freud would say the ego ideal) and the other patients (who represent the siblings). He experiences the receiving of understanding from the just parent whom he shares with all the other siblings and they are all equal in the eyes of the parent."[1]

It cannot be emphasized too strongly that it is through the emotional ties in this group relationship—through the catharsis in the family—that the important therapeutic effects are achieved. Through them the patient is encouraged and enabled to experience feelings and attitudes, affectionate or hostile, which previously he feared to reveal. By experiencing these emotions, which are similar to those he had in his childhood toward his own parents and siblings, he is able to release his repressed conflicts without the fear of punishment. In his acceptance as an equal and because of the favorable regard of the therapist (the father figure) and the other patients (the siblings) he finds the libidinal gratification that

enables his ego to accept more adult and realistic goals. This ability to function on an adult plane enables him to go out in the world and become socialized.

Freud, in discussing the formation of groups, describes somewhat the same sort of development. He repeatedly emphasizes that the nature of the tie that holds the group together is a libidinal one, and the members of the group are united by identifying themselves with each other through their libidinal ties to the same object—the leader. Freud postulates that this first occurred in the primal horde—the primitive family group. He makes the point also that this object relationship is based on an idealized, inhibited sexual aim and on the substitution of the object (leader) for the ego ideal of the members of the group. He gives as the formula for the libidinal constitution of groups the following: "a primary group of this kind is a number of individuals who have substituted one and the same object for their ego ideal and have consequently identified themselves with one another in their ego."[5]

The emotional acceptance which the patient experiences in the group encourages him to forego the fears which isolated him originally. He develops more adult and realistic social relationships within the group and with the outside world. This was shown several months after the group sessions began by the spontaneous formation of a social group among the patients. About nine or 10 of them would meet once a week or so at each others' homes and spend an evening together.

Results

During the period of the year covered by this report, a total of 23 patients was admitted to the group at various intervals. Of these, nine came for only a few sessions and then dropped out; these nine cases are not included in the results. The remaining 14 patients came for most of the group sessions.

The diagnoses of these patients included the following: one with manic-depressive psychosis (in remission), two with neurotic or reactive depressions, three with obsessive neuroses, two with anxiety hysterias, and the remainder with anxiety states. Most of the patients had some degree of character disorder also.

Three of these 14 patients were only slightly improved after the year of combined treatment. The other 11 were much improved. There was not only a marked lessening or a disappearance of their

symptoms, but a marked improvement in their adjustments. All of them exhibited better relationships with their families and friends and had much better social lives. All were better adjusted at work and two had obtained better jobs. Specific examples may be cited.

A housewife with a reactive depression and an obsessional character, whose marriage was on the verge of a break-up, was getting along with her husband much better than she ever had. A man of 25 with anxiety and marked feelings of inadequacy, who had been changing jobs constantly and who had had almost no social life, was in the fifth month of a new job and was going out regularly. A hostile and suspicious woman who had drifted from one quarrel to another at work and with her friends was happily settled in her job and had established new social contacts that were very satisfactory.

As noted previously, all these patients received individual psychotherapy as well as group therapy. No attempt will be made to evaluate the relative effects of the two types of therapy.

However, the observations of the psychiatrists who were giving individual therapy concerning the effect of the group therapy are of interest. They all felt that the group sessions were stimulating experiences for the patients and had facilitated individual therapy by aiding the release of repressed material.

The results might be best illustrated by quoting from the spontaneous comments of the patients themselves.

A woman said: "Since I have come to group therapy, I feel much better. I have lost some of my inferiority complex. I am not afraid to speak up any more. I feel now I know how to handle my problems and most of the time I am successful. . . ."

A man said that the group sessions had given him a better perspective as to what was troubling him. He added, "By listening to others I get an idea of other people's problems and this simplifies mine. Since I have been coming here I have learned quite a bit about myself. . . ."

Another man said, "Group therapy has made me live like other fellows. It has made me able to speak easily in groups. It helped me to get along with other people and to understand myself better. . . ."

Conclusions

Experience obtained during a period of a year with the use of group psychotherapy on out-patients has demonstrated that this form of treatment can be successfully used in an out-patient clinic. Our observations indicate that even in a clinic setting, it is possible for the therapeutically-important emotional relationships to be established: namely, the patient-to-therapist transference and the patient-to-patient identification which lead to a group formation similar to that in the family. Through these relationships, by means of a process that might be designated as "catharsis in family," the working out of underlying emotional conflicts is facilitated.

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A PROGRAM OF GROUP PSYCHOTHERAPY IN THE TREATMENT OF CHRONIC MENTAL ILLNESS*

BY JOSEPH J. GELLER, M. D.

I. Introduction

Group psychotherapy as a definite treatment entity has been in use since the early part of the twentieth century, having had two separate points of origin. It is of interest that this double beginning was different in point of geographical origin, as well as ideological orientation. Pratt, who in Boston in 1906 began what was later to develop into a definite technique of group psychotherapy, had, as his primary aim, the establishment of a method of reaching groups of people, rather than individuals, as a time-saving and personnel-saving measure. Moreno, who began his group work independently in Vienna in 1908, approached the problem from the standpoint of the value of interaction of the individuals in groups. That is, Moreno acted with the idea that therapeutic results, over and above those obtainable in the classical patient-physician relationship, could be obtained through the medium of group interaction. These two aims: reaching greater masses of people, and using group interaction therapeutically, have remained the bases of present-day group psychotherapy techniques.

The early work with group psychotherapy, as with psychotherapy in general, was started with nonpsychotic patients. The application of this new technique to the treatment of psychotics came more quickly however, than a similar extension of individual psychotherapy to the psychotic patient. Undoubtedly this was because it was seen that group psychotherapy was a method theoretically suited, on the basis of its large-scale applicability, to the masses of people making up the populations of the hospitals for the chronic mentally ill.

A survey of the literature on the application of group psychotherapy to psychotic patients shows the following efforts of the early workers. Lazell,[1, 2, 3] starting in 1921, used what was essentially a lecture discussion method. He gave talks on psychological subjects (with a psychoanalytic orientation), presented inspirational material, and gave an opportunity to the patients to discuss

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the material that had been gone into. He appreciated the value of the group situation, stating that "man cannot be an individual free of other people," and apparently utilized this concept in his work.

Marsh,[4, 5] starting in 1931, conceived the idea of applying psychological principles to the suggestive and inspirational elements of the revival meeting. He spoke of this method as "the psychological equivalent of the revival meeting." He worked out detailed plans for holding such meetings and reported considerable success along these lines.

Moreno[6, 7, 8] began extending his psychodramatic methods to hospitalized psychotic patients many years after his first beginnings in group work. One could not do full justice to his multiform works and ideas in a short summary. However, it appears that spontaneity, creativity and catharsis, are stressed as processes through which a state of healthy mental equilibrium can be obtained, and psychodramatic methods are considered the best media in which these processes may take place.

Wender,[9, 10] starting in 1936, gave as his expectations for group psychotherapy, the achievement of release of certain emotional conflicts, partial personality reorganization, and increased capacity for socialization. He based his work on psychoanalytic principles, and utilized material produced by the patients.

Blackman,[11] Jacobson and Wright,[12] Altschuler[13] and others[14, 15, 16, 17] have used group psychotherapeutic methods, but with little deviation from previously developed techniques.

A large scale group psychotherapy program was begun at the Central Islip (N. Y.) State Hospital in January 1947. This procedure had been in use on a small scale in the hospital's outpatient clinic but in January 1947 it was instituted for intramural use, on a more extensive basis. Its inception was part of a broad plan to develop methods of treatment suitable for large scale application to patients with chronic mental illness.

Specifically, it was felt that group psychotherapy could help considerably on an individual basis in terms of analysis and resolution of the individual patients' problems. By enabling patients, even in groups, to talk about their conflicts, reassurance and explanation would be possible; and, further, many problems touched upon by one patient would probably apply to others, thus enabling

such problems to become verbalized, and conscious to some extent, for all involved.

The value of a group setting as a means for patients to achieve a degree of awareness of other people, an effect of the group situation itself, would also be desirable. In addition, in this setting, patients could see the emotional problems of others and lose much of the fear based on the feeling of the solitariness and uniqueness of their own symptoms and problems.

Within a short while after the inception of the program, it was in use in most of the services of the hospital where the character of the patient population was such as to make it feasible. Later, several social workers were assigned to work part time in this program. They served two functions; that of acting as recorders for sessions held by the psychiatrist, and of handling activity groups themselves under psychiatric supervision. This paper presents the results of 18 months of group psychotherapy with groups of patients who represent most varieties of severe, chronic psychiatric illness, i. e., the typical case load of the state hospital. There follows a detailed account of the principles used, the administrative procedures, and the results which were obtained.

II. Management of the Program

With the object in view of determining whether this was a treatment method of fairly wide applicability to state hospital patients, it was decided from the outset to apply it to representative groups of the entire hospital population. However, even with this broad objective, patients were excluded who could not be expected to respond to this type of therapy. Such patients were those with advanced organic mental illness and those who showed advanced deterioration. To reach different types, the groups for therapy were arranged on the various services throughout the hospital. Since each service was roughly distinguished by the type of patient it had, in terms of behavior, chronicity of illness, age, and sex, this was a convenient means of reaching the different groupings which had been created by years of practical experience. Obviously, this meant that each group was heterogeneous in terms of diagnosis, psychodynamics, and problems in living. It was felt that since this was the type of grouping found in the average mental hospital, and, as a matter of fact, represented the form almost any but the most carefully and discriminately-chosen group of patients would

take, the method was the most practical to use for developing a treatment program suitable for large scale usage.

Although such heterogeneous groups were used in the greater part of the program, two were selected on the basis of homogeneous clinical features. One of these consisted of overproductive manic and paranoid patients. The other was made up of withdrawn, under-productive schizophrenic patients who retained some contact with the environment. Results with these special groups, as well as with the program as a whole, will be discussed.

Patients were chosen by the physician in charge of each service, slightly in excess of the number actually desired for the group. The patients selected were the "best" on each particular service in terms of accessibility and intelligence. They were then seen individually by the physician doing the group psychotherapy, after which the group was made up. This interview served to familiarize the patients with the group process, and enable the therapist to determine some of their individual problems.

Groups of 10 to 15 patients were soon found to be of optimum size. More patients made individual participation too limited. With a smaller number, group dynamics did not develop as readily or to as full an extent. Although the original idea was to form one therapy group on each service of the hospital, two groups were established in some cases when substantially more than 15 patients appeared likely to be especially helped.

Psychotherapy sessions of an hour each were held once weekly, for most groups. In especially responsive and active groups, a second weekly session was added. The sessions were conducted in convenient places on the patients' own wards in familiar, informal surroundings. A permissive and friendly atmosphere was maintained, and the patients themselves were encouraged to furnish the topics for discussion.

In addition to the initial interview at the time the patient was selected for group psychotherapy, the patients were seen individually at irregular times throughout the course of the sessions, in order to supplement the value of the sessions and to ascertain the patients' attitudes toward them. In addition, the patients were seen again individually when group psychotherapy was terminated for each one. Termination for individual patients occurred when they were released from the hospital. Less often, some patients asked to drop out for various reasons, and last, on rare occasions,

patients were dropped from the program when they were consistently disruptive or disturbed.

Patients were taken into groups at any time, since there was no formal program; and, similarly, they were released at unscheduled times, according to their times of release from the hospital. Consequently, the character of any group was a slowly-shifting one, the rate, of course, depending upon the degree of illness of the patients in the group. Thus on a service where patients were not too ill and responded well to treatment, release and intake of patients were more rapid than on a service where the severity and chronicity of illnesses were such that change was slow.

It was considered desirable to establish a system of record-keeping to give information to the physicians on various services who were responsible for caring for the patients, as well as for future evaluation of results. Two types of records were kept. The first was of reactions and productions at each session. At bimonthly intervals (monthly intervals when sessions were held more than once weekly), these findings were entered on a special form so that the consecutive findings on each patient for the eight sessions were on one sheet of paper, on the reverse of which the therapist summarized the findings for the period. Thus the other physicians were informed of progress and other matters. The second record was a running account of the topics raised, the extent to which they were developed, and the subsequent ideas to which they gave rise. It is felt that this serves to allow the therapist to evaluate concretely the depth of therapy and the general trend of the sessions. Over a long period, a review of this type of record permits a determination of the common problems of the patients and affords a source of topics for selection by the therapist.

III. Theoretical Concepts and Results

The main approach to treatment was the analysis and interpretation, along analytic lines, of material raised by the patients. There was not, however, any attempt to interpret immediately each statement, dream, or concept presented. Rather, the patients themselves were encouraged to develop, criticize, and "personalize" material which arose. Only after discussion at length would interpretations be given. In fairly obvious situations where other patients were able to detect features which were valid, ready concurrence would usually be given by the physician. In general, the

physician retained a seemingly passive role to insure development of discussion along lines best suited to the patients, as determined by their own productions. He participated to the extent of clarifying disputed issues, emphasizing important points and subtly drawing forth ideas related to topics under discussion, as well as by leading the discussion to important features of topics raised. Interpretations were, in all cases, fairly evident by the time they were made. Interpretations based on incomplete or wholly symbolic data were withheld until they were definitely substantiated. On occasion, when the discussion lagged considerably or the group as a whole was apathetic, leading questions would be asked to stimulate discussion. If these were not productive, broad topics were introduced, based on general psychological themes. The idea was repeatedly stressed to the patients that they were not attending classes at which they were expected to learn certain facts about human behavior and thought, for this was early found to be a misapprehension of some patients when they first began attending. It was pointed out instead that, as various topics arose, they were to serve as illustrations of the manner in which mental mechanisms caused certain psychiatric symptoms and that where particular features seemed to apply to oneself, further discussion was indicated. It was explained that the development of insight into one's own illness and the ability to live comfortably with others were the aims of the treatment.

The results achieved with this procedure are difficult to present in terms of any wholly objective statistical data. This is true not only because of lack of numerically measurable criteria of change, but because the patients, as was mentioned, were receiving the benefit of all other phases of the hospital treatment-program concurrently. The results can be much more readily discussed in terms of material produced and on the basis of levels of psychotherapy.

At superficial levels the following results were seen. The most consistent finding among the patients was the presence of hostility against the hospital and its personnel. Although some of this can be postulated as caused by unconscious motivations directed against figures in authority, a large part of it is related to the legal proceedings accompanying admission to a state hospital. Thus, the patient is arbitrarily assigned to a hospital and is, in fact, often obliged to go to the hospital against his will. Similarly, when

he reaches the hospital, he has little choice in the matter of the physician who is to take care of him or even of the ward to which he is assigned. These proceedings, unavoidable as they are and as diplomatically as they may be handled, inevitably will give rise to hostile feelings. As new patients first come to the therapy groups, they are rather quiet; but as they gain some measure of security and confidence, critical remarks about the hospital and its personnel begin to make their appearance. When it is pointed out by the other patients that many of these criticisms are without foundation, and when the patients are further led into a discussion of their manner of hospitalization, they usually see the real basis for their complaints.

This type of hostility, which in essence is a secondary overlay on the original psychiatric illness, is quickly and easily dispelled, and this is as would be expected on the basis of its recent development and superficial psychogenesis. Along similar lines, the opportunity afforded in the group sessions to get correct information about administrative and other matters of hospital policy seems valuable too. The frequent repetition of certain questions and ideas indicates that misapprehensions about many such matters exist. These are based on hesitancy on the part of some patients to inquire of proper authorities; on rumors and misinformation present in any group; and on a marked tendency to rationalize, and create explanations for the most minute and inconsequential acts and statements of the doctors, nurses, and attendants. This last borders on a transference phenomenon, but lacks any real projection features and has a fairly substantial basis in reality, even though the conclusions reached are often incorrect. In any case, the group situation wherein comments and questions are expected, and where neither censure nor criticism comes from anyone in authority, seems to be an atmosphere conducive for the allaying of fears and anxiety based on incorrect information.

An unexpected result of the therapeutic groups has been their effect on other patients in the ward. Much of the informative material received, especially correction of mistaken ideas, has been carried back to these other patients. There has also been mention made of the psychological material which has been gone into. Thus, the patients in the therapy groups have acted in a small way, as a kind of focus of dissemination of some of the ideas they have acquired.

The deeper effects of this form of treatment have been those that pertain more specifically to the individual's psychiatric problem itself. In a general way, even those parts of sessions which are devoted only to the foregoing material serve to develop feelings of greater acceptance and security. More specifically, other features have been noted. These sessions provide a good opportunity for the ventilation of hostility and, in milder form, of resentment. Usually this is directed against members of families, or former associates. Beyond the idea of ventilation alone, efforts are made by the therapist to help the patient develop some insight into such feelings when they exist. An important help in this respect is the criticism other patients make of the occasionally lengthy diatribes which occur. Here, the comments of other patients as to the irrational and bitter nature of much that is said at such times seem to be more valid to the patient involved than similar comments from the therapist. It is as if a transference feeling of hostility toward the therapist occurs along with the tirade against the significant person. This feeling serves to strengthen the bond between members of the group and, consequently, there is more weight attached to what other members say. Thus, in some cases, this serves to awaken the first doubts in the patient of the reality of his ideas; and further help for him becomes possible.

The symptom of anxiety is another thing that in certain cases has been helped in the group situation. This has been particularly true of anxiety secondary to uncertainty and fearfulness over specific symptoms. The discussion of symptoms in front of others, in addition to serving a cathartic function, has a reassuring effect on the patient when he finds the reaction of other patients is not one of fearfulness or horror. This reassurance is further reinforced when other patients relate that they have the same or similar symptoms, and the patient thus becomes aware of the lack of uniqueness of his particular problem. Anxiety of a more obscure character has not been so easily handled. In general, patients who from time to time have shown such anxiety have obtained some relief from the reassurance afforded by the accustomed security of the group situation.

In many cases, where a particular problem is introduced by one patient, the recall to memory of similar problems by others in the group serves to help develop awareness in each of the patients of

additional phases of the problem involved. During the ensuing discussions, additional insight becomes possible, and of course, the explanations given are in a broad sense often common to several persons.

A sense of unity has developed among many of the members of the groups. In some cases, the patients concerned noted this feeling as more free and intimate than most other interpersonal relations they had previously set up. This was probably based upon the common grounds of interest existing between the patients, and the fairly benign and non-threatening atmosphere of the group situation. Some of the patients involved have tended to form relationships which have persisted beyond the group situation, a definitely desirable reaction.

The deepest effects of treatment have been in those instances where valid interpretations have been made of underlying problems with resultant development of insight. Such instances, although not infrequent, were less common than any of the previously mentioned features. There have been no cases where results approaching complete analysis and resolution of any one individual's difficulties have been accomplished. Any such complete analysis was, of course, hardly to be expected, both because of the relatively small amount of time involved and the severity of illness these patients showed. In general, this type of interpretation has been limited to material actually worked out and accepted by the patient. It has been carefully held to this point. When more basic causation has been evident, efforts have been continued to go deeper into the material.

An illustration of what was done may clarify these explanations. A 27-year-old married woman—when she had become adjusted to the group situation—began telling of her strong love for, and attachment to her children. Both the patient and the other members of the group remarked on the splendid state of affairs such a relationship seemed to represent. When the patient was further drawn out along these lines, it soon became apparent that there were many elements of overprotectiveness and oversolicitude present; and, soon, most of the other patients could see this, and were calling it to her attention. It took more time for her to begin to agree to accept these as facts but ultimately she did so. She then began justifying such behavior on her part, basing it largely on childhood deprivations of her own. It then became evident that

she had been subject to parental rejection and neglect, and other members of the group began calling this to her attention. She took additional time to recognize this, and then began connecting incidents in her own childhood to ways in which she had actually been mishandling her own children. Obviously, there is much further distance for her to go along these lines; but even to reach this point, has taken several months. Numerous other similar results have occurred. They take place over a long period, and are the ultimate development of many separate group psychotherapy sessions—which are interspersed with features about other patients than the one thus benefited, with discussions of administrative interest, and with discussions of topics of general interest brought out by one or another of the patients.

Results with the two special groups of patients mentioned earlier have not been especially gratifying. The group made up of overtalkative and aggressive manic and paranoid patients was instituted to determine whether a start toward the development of insight into irrational thinking and productions would become possible when patients came into contact with others who showed these same features. This effort was not notably successful, for after about eight weeks, individual patients began dropping out, mainly on the basis of being unwilling to put up with the "obnoxious" and "forward" habits of "those other people" present. Obviously, the motivation for the aggressive and hostile trends was sufficiently strong to make such traits in others unendurable, and also, of course, to prevent the patients from recognizing these characteristics in themselves. In the brief time it was possible to keep them together, these patients showed no benefit from this type of therapy, when treated in homogeneous groupings.

The other special group, consisting of withdrawn schizophrenic patients, was made up to determine whether attempts at a group method of discussion would be beneficial for this type of patient. Although it has been possible to keep this group of about 10 patients together for over a year, the only overt results which have been obtained are meager. Patients have developed occasional recognition of some others by way of commenting about what others have said. One patient has begun to show coyness and has developed a simpering manner. Several have begun to demand release from the hospital, this being some evidence of awakening interest in external events. Others have certainly become aware

of the therapist's personality but have shown little change themselves. This particular group has been conducted mainly by stimulation of discussion with simple questions. Although results have been noted, they are extremely slow in development and it would undoubtedly be necessary to continue this type of treatment for many months to see marked improvement, as long as homogeneous groupings alone were used.

All of the foregoing results have been obtained by the method of the permissive-discussion, group arrangement described. This has constituted the bulk of the group psychotherapy program. Twelve to 14 group sessions are being held weekly, and have been continued uninterruptedly since their inception in January 1947. As the various administrative difficulties in handling them were adjusted and more time became available, it was decided to add additional features to this program. It was felt that activity-group therapy conducted by social workers under the direction of a psychiatrist would be a worthwhile endeavor and this was accordingly started in July 1947. At present, this phase of the program consists of separate, current events discussion, dramatic, and English grammar and composition sessions. None of these is intended to serve as an actual class in the particular subject covered but rather as a means of affording the patient an opportunity for expression and in a general way acting as a socializing and confidence-instilling measure. These sessions are held once weekly, for an hour at a time. Once a month, the social workers who conduct them meet with the psychiatrist in charge of the group psychotherapy program. At that time, there is discussion of problems, achievements, and criticism of the social workers' sessions, as based on the reports of them. This type of therapy has been received with interest by the majority of patients and serves a useful function as a means of stimulating spontaneity, thinking and discussion.

Another extension of the group psychotherapy program was begun in October 1947. This consisted of the establishment of preconvalescent-status orientation sessions. These sessions have been set up as a lecture-discussion arrangement wherein, once each week, all the patients who have been approved for release from the hospital during the preceding seven days are brought together at a central point for indoctrination. Primarily a matter of conveying factual material to the patients about the purpose of con-

valescent status, discussion about any or all of the points which may be mentioned is encouraged.

The material given is presented under three main headings. First, the psychiatrist gives a factual discussion of the reason for clinic attendance, and the features of the clinic services. Included, are explanations of possible difficulties the patient may encounter when he first leaves the hospital. The question of whether any stigma need be attached to mental illness is thoroughly discussed; and the attitude of potential employers toward persons recovering from mental illness is gone into. The manner in which the clinic facilities can offer positive help in any of these respects is emphasized, and affiliations with the New York State Employment Service and the Division of Vocational Rehabilitation of the New York State Education Department are brought out. The second part of the program consists of a talk by a social worker who gives an idea of the social worker's functions and the various ways in which she can assist and advise the patient. This is gone into in some detail, so that patients may become fully aware of all the ways in which the social worker can be of help. The final part of the program, is a talk by the psychiatrist, on certain aspects of preventive psychiatry. In a simple way, the concept of psychic trauma, the effect of overwork, the value of a normal program of activity, and similar matters, are discussed. Throughout the discussion, the patients have opportunities to inquire about anything that comes to mind, and they are asked to interrupt at any time. It is stressed at several points, that the entire program of convalescent care has been arranged to benefit the patients and to prevent their return to the hospital by helping to further their recovery. It is emphasized that clinic attendance and the social workers' visits are to promote this aim and are not primarily in the nature of custodial surveillance or in any other way a policing function. While it is a little early to determine the over-all value of these orientation sessions, the patients themselves give indication of interest in the material presented, and the social workers report a more ready acceptance of their home visits than before these sessions were begun.

IV. Summary and Conclusions

A program of group psychotherapy now in use at the Central Islip (N. Y.) State Hospital in the treatment of chronic mental illness, has been presented.

1. The principal type of group psychotherapy used was a discussion session in a friendly, permissive, non-critical atmosphere, with the bulk of the material being introduced by the patients themselves. The psychiatrist played a relatively passive role, drawing the discussion out, directing it toward important areas, and interpreting pertinent material as the occasions to do so arose from time to time.

2. This is a method which is adaptable to the large scale treatment needs of the state hospital.

3. The effectiveness is proportional to the degree of illness of the patients under treatment, just as with any other psychotherapeutic techniques. The milder the illness, the better the results obtained.

4. Results were at two main levels. There was clarification and understanding of presenting problems at superficial levels, and there was analysis, at deeper levels, of underlying problems, with development of true insight. The former was more quickly and more frequently accomplished than the latter.

5. A qualitative increase in the degree of improvement of individual patients leaving the hospital was more apparent, as a result of this treatment program, than any marked quantitative increase in the actual number of patients being discharged.

6. This method of group psychotherapy is not a substitute for individual psychotherapy. It is an addition to the treatment armamentarium rather than a substitute for any part of it. Its chief value lies in the acceleration of treatment, and in the smaller amount of individual psychotherapy needed, when group therapy is used.

7. Modified group activities directed by psychiatrically-oriented personnel, working under psychiatric supervision, are being elaborated.

8. A group method of orientation of all patients leaving the hospital is being undertaken and promises to be helpful and beneficial.

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A PHILOSOPHICAL BASIS FOR BRIEF PSYCHOTHERAPY*

BY CARL A. WHITAKER, M. D., JOHN WARKENTIN, M. D., AND NAN JOHNSON, M. S.

This is a report of the use of a variation in the process of brief psychotherapy, that of two therapists treating one patient. This method has been used experimentally for three years. It has seemed valuable in teaching the art of psychotherapy.

The immediate objective of the procedure was to develop the capacity of the therapist. This aim is in agreement with Dr. Betz of the Johns Hopkins University, who has said that "the dynamics of psychotherapy are in the person of the therapist." The long-range objective was to develop concepts that would facilitate the teaching of psychotherapy.

The experimental method consisted of having two therapists conduct jointly the entire course of a patient's treatment. It developed from an effort to share with each other the emotional experience of the therapeutic interview. At first, the second staff member sat in on the interview as a visitor and as a critical observer. It was difficult to overcome the threat and embarrassment which the therapist felt at having a second staff member observe him in a deep emotional relationship.

The second therapist, however, soon became dissatisfied with his role during the interview and was allowed to participate more actively. This did not seem to disturb the therapeutic process. In fact, treatment was often augmented by the participation of the co-therapist. It seemed to make little difference whether he supported or disagreed with the therapist or the patient, or expressed his feeling about their interrelationship as he saw it. The co-therapist often saw and utilized inferences or cues which otherwise might have been overlooked, so that the treatment process was facilitated. A disadvantage of the method was that the presence of the co-therapist seemed to restrict the capacity of some patients to verbalize, but this did not appear to affect the therapeutic effectiveness. A patient might have verbalized more psychopathology to an individual therapist than he did in the presence of a co-therapist, but participation with the two appeared to hold greater significance for him.

*This paper has had a limited circulation in mimeographed form to the A. P. O. mailing list of the United States Navy.

This technique led the therapists to challenge each other following the interviews, especially in relation to the feeling tones. It soon became evident that, to function smoothly, the two therapists had first to resolve their immediate relationships to each other.

The give-and-take during and after these interviews was emotionally charged for both therapists, and thereby made possible a more complete perception of the therapeutic process. Because feelings were discussed and evaluated, the verbal content was seen in better perspective. They struggled to resolve the many differences which arose in their functioning. The unconscious overtones of one therapist were repeatedly picked up by his colleague; and, periodically, it seemed as if whole new vistas were opened up in their professional insight. Instead of building up a false intellectualization, their free association helped each to see more of his own emotional functioning in the interview. This highlighted the differences between them and made for professional growth.

The remainder of this paper will be concerned with the elaboration of three principles and how they relate to the functioning of the therapists themselves: (1) The therapists should be directive in developing an emotional relationship with the patient. (2) They should consistently refuse to participate in the patient's real life or its decisions. (3) A "healthy counter-transference" is the crucial force in treatment.

Concerning the first of these three conclusions, the therapist—in developing an emotional relationship—is dominant in setting the stage for the treatment process. He attempts to restrict the interview-situation so that the patient cannot use the ordinary means of social communication and must search for a new way. This atypical situation is intended to facilitate the release of deeper forces in the personality, such as aggression or sexuality, and to create a dream-like atmosphere within the interview setting. The emotional warmth of the therapist serves as anesthesia to help the patient suffer through the "operation" of integrating his personality. It is vital that the therapist give the patient enough warmth to make his ordinary defenses less of a barrier in the office interview situation. The abstract nature of this type of interview, and the inability of the patient to apply any of it directly to his behavioral living, forces the patient to search for ap-

plication to his subjective living and thus to begin changing himself instead of conversation or behavior.

One specific technique for denying a social relationship in the interview is the use of silence on the part of the therapist. Such a silence must not be merely a retreat from the interview. Silence may force the patient to experience the uniqueness of the situation and its directional orientation. It demonstrates that the therapist will not take the initiative at that point. Whether he feels hostile or accepting, silence focuses the emphasis on the patient's fantasy life. Silence increases the symbolic power of the therapist. All this observation is valid if the therapist overcomes the temptation to use the silence for his personal fantasies, rather than to increase the therapeutic pressure on the patient. Subsequently, words usually carry a deeper emotional charge and it is easier to avoid the impotence of an intellectual therapy.

The orientation of the therapist largely determines the depth to which the therapeutic relationship can be used by the patient. It is necessary to clarify the functional limits of the interview-situation to reduce the need for conscious techniques by the therapist. The unconscious of the therapist can thereby be released to relate more freely to the unconscious of the patient. Therapy limited in this way, to dealing only with the emotional and symbolic aspects of the relationship, can be adequate in itself to effect a successful therapeutic outcome. The criteria for this success are measured in terms of change in the patient's orientation and not in any overt change in behavior or symptomatology. It becomes apparent that in this sense any patient can be helped.

The second major conclusion reached by the writers is that the psychotherapist should not participate in the patient's "real life." The term "real life" is used to designate everything except material which has symbolic power that is available to the patient for his emotional growth. To minimize the factors which interfered with the development of the transference, the therapists freed themselves of all responsibility in the patient's real life. The more completely the therapist could be a stranger to the patient's real life, the greater was his symbolic power. For example, the therapists refused to allow the interview to become an after-dinner conversation; any social friendship was avoided; and no factual questions were asked. A therapist impaired his symbolic status if

he said to the patient, "Tell me your life history." Instead he might say, "How can I help you?"

The experiment gave evidence that when the therapists reassured the patient, or made any suggestions as to how the patient should live outside the office, or even discussed with him the medical or psychopathological implications of his symptoms, it was a dangerous interference with the psychotherapeutic process. The therapists tried to offer themselves, rather than to demand of the patient, who came already emotionally impoverished. In addition, the therapists did not need to know the psychopathology of the patient and it was not their function to try to find out—because they carried no administrative function.

In this experiment, a separate psychiatrist who was not seeing the patient in therapy, assumed all administrative functions. These included medical, social, psychological and psychiatric work-ups. In some instances, it worked well to relegate the administrative function to the referring doctor. In this manner the struggles of real life did not become issues in the interview, and the therapists were less likely to fulfill the role of the real parent.

The third conclusion is that counter-transference is the fundamental force in brief psychotherapy. Even though the therapist is skillful in excluding real life and in centering the relationship in the emotional area, he may still fail if he has an inadequate response to the patient. An inexperienced therapist often filled the therapeutic role adequately with anxious, child-like patients but had difficulty with the patients who required a greater degree of warmth. When he was unable to give enough warmth, he was in danger of developing a pathological counter-transference. This pathological counter-transference was a basic problem of the inexperienced therapist who tried to learn psychopathology from a patient, or who tried to satisfy some of his own drives. Thus, such a therapist found himself satisfying his need for power by "playing God" or his need for affection by being the boyfriend. This type of counter-transference stands in contrast to "the love that sets one free." To the extent that the therapist took satisfaction from the patient and the relationship, he was rejecting his own role and rejecting the patient as well.

It is necessary to differentiate two types of counter-transference: pathological and therapeutic. The warmth of the mature therapist may well be called a therapeutic or healthy counter-

transference. He brings to each therapeutic situation the capacity and readiness to give. The "giving" of the mature therapist is best described in terms of the feeling the child should get from the parent. The mature therapist is consistently parental. This parental role, as the therapist lives it, includes emotional support, definition of limitations, the capacity to accept aggression and the ability to give without needing repayment.

The experiment was planned to develop a setting which would enable the therapist to utilize this healthy counter-transference to eventuate in a constructive termination of therapy. The more mature the counter-transference, the greater can be the patient's use of his transference in the furtherance of his growth. The adequacy of the counter-transference will be most evident in the degree of motivation shown by the patient in bringing his therapy to a conclusion.

The writers believe that the therapist must have therapy for himself in order to participate emotionally with the greatest number of patients. Wherever the therapist has significant conflicts of his own, the patient may precipitate the doctor into fantasy about himself. If the therapist has had an experience in the patient's chair, he will have some emotional understanding of the patient's role, will feel more secure in helping him suffer, and will be less apt to switch chairs with him in mid-interview.

This experiment in brief psychotherapy was an effort to foster the development of a better therapeutic relationship. It resulted in the formation of a constricted and synthetic interview situation, which seems to help the therapist to meet more adequately the needs of the patient. The therapist can then help the patient break the pattern of child-like attachments and disappointment, which the patient has experienced over and over in his previous life. Once that structure has been broken, by the help of a mature counter-transference which makes possible a constructive "ending," the old pattern can never enslave the patient again to the same degree.

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A SCHIZOPHRENIFORM PSYCHOSIS WITH PERNICIOUS ANEMIA--- A CASE REPORT*

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Dementia præcox associated with, or bearing a direct relationship to, somatic disease has been frequently described in the literature. There is no condition in the medical literature which has been subject to more diverse opinion and more ingenious theorizing than dementia præcox. The failure to find a uniform etiologic agent or a consistent neuropathology has caused investigators to wander far afield and indulge in complicated mental gymnastics. This has been interesting but rather sterile of results. The purpose in this paper is two-fold. The first is to point out that psychosis may occur as a direct result of pernicious anemia. This has not been universally accepted. The second is to present the evidence which tends to show that the symptom complex of dementia præcox may be the presenting mental manifestation of pernicious anemia. As a corollary, we believe that it is possible to explain the psychoses as easily on the basis of an organic brain disease as on the more complex and newer functional basis.

Broadly speaking, there have been two schools of thought regarding the etiology and pathogenesis of dementia præcox. On the one hand are those who believe in a purely functional cause for dementia præcox, the abnormal reaction of the individual to experience as embodied in Meyer's psychobiologic concept, and on the other hand Kraepelin's and Bleuler's concepts of this condition as a physical disease. The consensus, and it is still only opinion, rests somewhere in between these two concepts.

Cases occasionally come to one's attention in which the mental symptoms very definitely fall into the group labelled dementia præcox, and in which there is a definite organic disease with the strong possibility of brain involvement. Specific treatment, when such is available, as in the case of pernicious anemia, often clears up the mental symptoms. There appears to be definite cause and effect in these cases. This leads us to the inference that dementia præcox is merely a syndrome, the result of some organic brain process of varying etiologies. Some of these etiologic agents are de-

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monstrable, as in pernicious anemia, occasionally in brain tumor, neurosyphilis, and arteriosclerosis. Other etiologic processes—and this encompasses the majority of dementia præcox cases—are not demonstrable with present methods of study. But this has been true of other diseases, the status of which eventually became clarified as techniques for studying them improved.

The relationship of psychosis and pernicious anemia has been dealt with from many aspects in the literature. Numerous cases have been reported of pernicious anemia with associated mental symptoms in which demonstrable brain changes were found. Barrett[1] in 1913 reported autopsy findings of cases of pernicious anemia at a state hospital in Michigan, in which the brain in eight out of nine cases examined, showed distinct changes in the cortex, although it was believed that these were of a non-specific nature. Lurie[2] reported four cases with necropsy findings and found the changes in the brain more extensive than those in the spinal cord. He stated that there was a fairly constant relationship between the clinical symptoms and the pathologic changes. He also concluded that the psychoses found in his cases could be classed with the symptomatic psychoses of an organic nature.

Adams and Kubik,[3] in an excellent paper, report two cases in great detail, and confirm the observation that cerebral lesions occur in pernicious anemia and that the cerebral and cord lesions are almost exactly alike in that the essential pathology consists of a diffuse though uneven degeneration of the white matter with little or no proliferation of the glial substance. Unlike Barrett,[1] these writers conclude that the cerebral changes are as specific of pernicious anemia as are the cord changes seen in subacute combined sclerosis. Cognizance is taken of the fact that in severe pernicious anemia there may be other associated nutritional deficiencies, with central nervous system changes secondary to the latter, as is seen in pellagra. It was further stated that the order of involvement of the central nervous system was: the posterior columns, the lateral and anterior columns and finally the cerebral white matter. They find that the pathology represents a specific process induced by a deficiency of certain substances necessary to the metabolism of myelineated nerve fibers. And finally, they conclude that every patient with pernicious anemia should not be expected to have demonstrable brain lesions but that in all those with

disseminated brain lesions, mental disorders were probably present.

Two interesting cases are reported by Richardson[4] from a series of 67 cases of pernicious anemia in which frank psychoses were present. Both of these patients exhibited delusions of persecution and hallucinations. Both recovered entirely from their psychoses, with liver therapy and the return of the blood picture to normal. One of these patients, following a lapse in diet, had a return of his psychosis, but this disappeared again under liver therapy. Many other mental symptoms were present in the group as a whole, and the comment is made that the improvement in these mental symptoms was as striking with liver as the improvement of a hypothyroid patient on thyroid medication. A similar series of cases with similar results is reported by Phillips[5] who warns that the mental symptoms may be so striking as to obscure the etiologic blood disease. The mental changes listed here varied from irritability and changing moods to paranoid psychosis, the latter being the most frequently encountered. Ferraro and English[6] also noted a paranoid state prior to the appearance of anemia in four out of five cases.

Bowman[7] reported on 23 cases of psychosis with pernicious anemia at the Boston Psychopathic Hospital. Twenty-two of the 23 showed definite psychoses. He stated that the time between the onset of pernicious anemia and the mental symptoms ranged from one day to a year or more and that there was therefore nothing consistent in this relationship.

This statement is certainly open to question, since the hematologic studies in that paper consisted chiefly of peripheral blood smears. The bone marrow is a far more sensitive guide to the status of the anemia than is the peripheral blood. It should also be pointed out that the onset of pernicious anemia may occasionally consist purely of mental symptoms. Furthermore, since pernicious anemia is characterized by remissions and exacerbations, the onset of objective symptoms cannot be used as indicative of the onset of the disease. Bowman lists among his cases 11 instances in which the mental picture was that of an organic confusion; three cases of depression; two cases of manic excitement; four cases of a schizophrenic reaction and two cases of a mixed picture of a schizo-affective reaction. It is interesting to note, therefore, the diversity of mental symptoms produced by the same disease, and,

while this may be explained on the basis of the different personalities involved as a result of different backgrounds, another and possibly more tenuous explanation may be differences in organic involvement, quantitatively and anatomically.

Paul Schilder,[8] in discussing this Bowman paper, felt that there perhaps was a specificity of the psychologic picture in pernicious anemia and that any organic disease involving the central nervous system must be connected with some definite alteration of the personality. Bowman concludes that in some cases the pernicious anemia is the direct and important cause of the mental symytoms, that in others it is mere coincidence and that in still others the pernicious anemia is the precipitating factor. In this connection, the writer must state that no one doubts that a psychotic patient may develop pernicious anemia, as a psychotic can develop tuberculosis, but we are not considering these cases here. It should be noted, too, that some of the reported cases of psychosis with pernicious anemia, in which the mental state is unaffected by liver, probably include just such instances.

In addition to the papers mentioned in the foregoing, there have been numerous other studies on the histopathology of the brain.[8, 9] That such changes exist in pernicious anemia has been amply demonstrated.

The statistical evidence of the incidence of psychosis in pernicious anemia is weighty, though the figures advanced, vary considerably.[10, 11] Cabot,[12] as long ago as 1900, commented on the large number of symptoms referable to the nervous system. Of 647 cases, 102, or 15 per cent, had mental symptoms. Young,[13] in an analysis of 515 cases of pernicious anemia, admitted to Peter Bent Brigham Hospital found an incidence of 4.5 per cent showing psychotic trends, including acute delirium, depressions and paranoid states. Herman, Most and Joliffe[14] found 15.7 per cent of 255 cases of pernicious anemia showing either acute confusional states, paranoid conditions, affective reaction or organic deterioration. Wiltrakis,[15] in 10 cases of pernicious anemia, found the diagnosis to be psychosis with organic disease in four; manic-depressive psychosis in two; paranoid dementia præcox in two; hebephrenic dementia præcox in one and psychosis with cerebral arteriosclerosis in one. Waltman[16] cites a 4 per cent incidence of outright psychosis and 35.2 per cent with lesser but obvious mental change in 1,498 cases at the Mayo Clinic.

Many other papers on this subject present different viewpoints. Darden and Hall[17] felt that a "toxic state" caused the mental symptoms in pernicious anemia. Hackfield[18] concluded that pernicious anemia bore no direct etiological relationship to the production of a psychosis but in some instances acted as a precipitating factor. De Natale[19] also believes that pernicious anemia may be considered only as a stimulating or aggravating factor in the production of the psychosis. As the other extreme, Osgood[20] believes that mental change with pernicious anemia is pure coincidence, and in a study of 76 cases found a family or personal history of previous mental disease (the latter type of case has been mentioned before and should be excluded from consideration). Mental improvement did not parallel physical improvement under therapy, and autopsy findings showed no constant relationship between the pathologic changes in the brain and the psychosis. This reasoning is, the writers believe, subject to considerable criticism. It is difficult to understand, on the one hand, the reluctance to accept mental symptoms as being caused by brain changes when these changes are grossly and diffusely present, and, on the other, the readiness to accept a functional explanation despite the presence of these organic brain changes.

Mention must be made at this point that rarely, in the literature, is the term dementia præcox or schizophrenia used to categorize the mental symptoms found in pernicious anemia, although unquestionably many of the cases presented would fall into this group were there no obvious organic disease present.

The following is a case report illustrating the syndrome of dementia præcox which the writers believed to be due to pernicious anemia.

Case Report

The patient is a 39-year-old, married man who was admitted to Northport Veterans Administration Hospital on November 1, 1947 as a transfer from another institution.

Family History. The patient is of English stock, resident in New England for many generations. His father had been a retired Universalist minister. He is described as stern and religious but tolerant and not given to criticism. The patient was attached to him. He died in August 1947 of carcinoma. The patient's mother is 60 years old, living and well. She complains of numerous minor

illnesses and used to stay in bed a great deal, during which periods the patient did the housework. The patient is the second of five siblings, the first being a boy two years his senior. This brother is now hospitalized with a diagnosis of dementia præcox, paranoid (since 1936). There is a sister two years younger than the patient. She is single and a school teacher. There are two other brothers, one single, a minister, 30 years old and the other 32 years old, married, with two children and in good health. The patient has not seen any of the members of his family since 1934.

Personal History. The patient was born in Provincetown, Mass., January 21, 1909. There is little information concerning his early development. He was shy, given to long periods of brooding over real or fancied mistakes that he had made, although he "was never criticized." He would day-dream for long periods. He was subject to tantrums, and enuresis at times and enuresis continued until puberty. There was no family discord reported.

He had the usual childhood illnesses, but no serious illnesses or operations were recalled.

The patient was considered bright. He began school at the age of six and went to high school at 12. Because of his father's duties, they lived in a constantly changing environment. He entered St. Lawrence University at 17 and was graduated at 21 from the theological school. The patient was unhappy with his calling and finally told his father he couldn't be a minister, whereupon the father obtained employment for him as a social worker.

For the next 10 years he was connected with a welfare organization in Pittsburgh, where he was the only man in the department and where he felt out of place and inferior. He worried a great deal about his cases who were, for the most part, boy delinquents.

The patient masturbated at an early age and suffered guilt feelings. He says he has since learned that these feelings were not warranted. He was married in 1934 at the age of 25 to a girl four years his senior whom he had known for two years. She is described as intelligent, healthy and of the executive type. She has always earned more than did the patient. His wife found him a shy, retiring person who would not stand up for his own rights. Their sexual relationship is described as only "fair," and the patient appeared unconcerned over a childless marriage.

Habits. There are no alcoholic or other toxic influences reported. The patient states that he likes sports but has no aptitude for them. He has almost no male friends and seemed to be content to live with his wife and sister-in-law and mingle with their friends who were all women.

Personality. The patient is a quiet, passively dependent individual, conscientious, sometimes suspicious, presenting a tendency toward brooding and daydreaming.

Military History. The patient was inducted into the army in May 1942. He was sent to a technical school for a course in airplane mechanics which he enjoyed very much, receiving top grades; but during his three years of service, which saw him promoted to first sergeant, he did only administrative work and felt miserable being with large groups of men.

Post-Military History. Following his army discharge in 1945, the patient joined his wife in New York, where she was then employed. He felt restless, "at sea," in doubt as to whether to go back to social work, and was under some pressure from his wife to make a vocational decision. Feeling the need for expert guidance, he joined an association sponsoring psychoanalysis. He wrote his father for money to finance an analysis but was advised to "give up Freud and grow up." He returned to social work and made a gradual adjustment which appeared satisfactory.

Onset of Present Illness. In December 1946, the patient's parents came to visit him. His wife noted "that his father hadn't been there a day before he had my husband back in the role of a six-year-old boy, forcing him to wait on him hand and foot and giving him no recognition as a man." From this time on, the patient became preoccupied, forgetful, retarded and careless about his appearance. Work at the office became difficult when he began to feel that he was being talked about and that he was "being taken for a ride and falling into a trap." He continued working but felt unsure of himself and wrote to his father asking for help. He received an answer telling him to "buck up." He became worse following this letter, had prolonged weeping spells, and talked steadily for a period of 36 hours, sometimes about his parents and their lack of understanding, at other times in a religious vein. He was taken to a psychiatrist; and he improved somewhat; but in a week he again became despondent and restless, and developed ideas of persecution. He was admitted to a hospital.

At this institution he received two series of electric shocks, a total of 24, with some improvement. He was diagnosed as dementia præcox, paranoid type, and transferred to Northport on November 1, 1947. It was noted during this first period of hospitalization that he complained of considerable pain in the calf of the left leg and of stiffness of the fingers, and that he walked with a rather awkward gait which he could control on request. There were no other objective neurological findings.

No objective findings were noted on the admission physical examination at the veterans' hospitals. Mental examination revealed the patient to be neat and tidy in appearance and co-operative in his attitude. He was somewhat vague, silly and manneristic and at times appeared anxious and tense, but his affect was generally shallow and inappropriate. He offered many somatic complaints especially about the difficulty in walking and about loss of memory for the year preceding his admission. He expressed fear of having syphilis or cancer or other incurable disease and complained of being self-conscious, and afraid that close proximity to other people "hypnotized" him.

He denied having any auditory hallucinations, suicidal or homicidal trends. He was correctly oriented in all spheres and showed some superficial insight into his illness. His judgment appeared defective.

This patient was diagnosed as schizophrenic reaction, paranoid type—"predisposition" was considered moderate and note was made of a brother in a mental hospital, a sister whose behavior was "withdrawn" and enuresis until the age of 12. The return from military service was thought to be the precipitating factor in the psychosis, and he was believed to have marked incapacity.

Neurological examination on April 13, 1948 revealed the following positive findings: gait, broad based and ataxic; deep tendon reflexes increased bilaterally in the lower extremities, particularly on the left with transient left ankle clonus; bilateral Babinski responses but no confirmatories; position sense lost in big toes, bilaterally; vibratory sense markedly impaired in both lower extremities; Romberg positive. The impression was: postero-lateral sclerosis.

Laboratory Data. Peripheral blood studies were not remarkable—the red count ranged from 3.8 million on admission to 4.88 million after liver therapy. There was a mild reticulocyte response to liver.

Bone marrow studies showed:

On April 26, 1948—36.0 per cent neutrophiles; 18.5 eosinophiles; .05 basophiles; 21.5 lymphocytes; 2.5 myelocytes; 3.5 megaloblasts; and 17.5 normoblasts.

On April 14, 1948—color index 1.17; mean corpuscular hemoglobin 34.21 micro micrograms; mean corpuscular hemoglobin concentration 27.65 per cent; saturation index 9.83; volume index 1.42; mean corpuscular volume 123.7 cubic microns.

On April 20, 1948 and April 22, 1948 gastric analysis showed no free HCl after histamine. The blood sugar on April 20, 1948 was 110 mgs. %; insulin tolerance normal. Van den Bergh on April 23, 1948 (before liver therapy) direct 0.8, indirect 2.4; after liver therapy, direct 0; indirect 0.7. Urinalysis was normal and negative for lead. The stools were negative repeatedly for ova and parasites. The spinal fluid was normal except for a slight increase in proteins. Complement fixation and colloidal gold tests were negative; the blood Kahn was negative. X-ray studies of the gastrointestinal tract, chest and spine were normal; the electrocardiogram was normal.

Course. Following the neurological examination and the blood studies, a diagnosis of pernicious anemia with subacute combined sclerosis was made; and the patient was put on intensive parenteral liver therapy. However, improvement in his mental status began before the institution of liver therapy. This was interpreted as due to the beginning of remission from his pernicious anemia. This was borne out by his peripheral blood picture, which did not show a marked anemia, his bone marrow study and reticulocyte response, which was only moderate.

There was marked improvement in his mental condition and gradual but less marked improvement in his neurological status. Repeated Rorschach tests following liver therapy indicated improved intellectual control, improved contact with reality and decline of indications of severe pathology. The patient had several leaves of absence during which he did very well and he was finally granted a trial visit home on June 15, 1948.

Discussion

A case is presented with the clinical findings of dementia præcox. This was treated as such with psychotherapy and a series of electric shock treatments. The existence of paresthesias and a staggering gait resulted in further work-up which established the diagnosis of pernicious anemia.

Specific therapy resulted in a dramatic improvement of his mental symptoms and some improvement in his subacute combined sclerosis as a result of which he was discharged from hospital. Since this report, another case of pernicious anemia was similarly treated on the medical service of the same hospital with good results. The response of the second patient was not so dramatic as that of the first, but his psychosis was of long standing and there was unquestionably irreversible brain damage.

The implication that dementia præcox is a symptom complex, the result of organic brain disease of varied etiology, appears to the writers to be very strong. There have been numerous cases of schizophrenia with acute surgical abdomens in which there was not only no complaint of pain but no objective evidence such as rigidity of the abdomen. In one such case, that of a perforated gastric ulcer, the patient appeared entirely comfortable and in the presence of a generalized peritonitis there was no tenderness or rigidity of the abdomen. X-ray evidence of air under the diaphragm was the only indication of a perforated hollow viscus. The absence of pain may be explained away on a functional basis, but not the absence of reflex abdominal rigidity. This, to the writers' minds, bespeaks an organic interruption of the nerve supply.

The cases at this veterans' institution of acute myocardial infarction, with no pain and often no evidence of anything amiss other than a diagnostic electrocardiographic tracing appear to be more frequent than the incidence of so-called silent coronary occlusion in non-psychotic patients.

An analogy may be made of the history of pernicious anemia and that of dementia præcox. Following Addison's description of idiopathic pernicious anemia in the middle of the nineteenth century, the disease was found to be fairly common up to relatively recent times. However, it was discovered that fish tape worm infestation produced the typical macrocytic, hyperchromic anemia found in pernicious anemia, so that disorders of this known etiology were detached from the idiopathic group. Gradually other

conditions such as liver disease, sprue, and carcinoma of the stomach were found to produce a similar blood picture and so they too were excluded. This left a much smaller group still labelled idiopathic. And so with dementia præcox, the syndrome—sometimes without gross organic psychiatric findings—was found to occur in central nervous system syphilis, cerebral arteriosclerosis, pernicious anemia and other organic diseases in which the relationship was more than just coincidental, as in the writers' case. The diagnosis in these cases may then be changed from dementia præcox to psychosis with other organic disease. This then leaves a large residual group of dementia præcox of undetermined etiology. It is this group which is now being belabored in an effort to give it a functional etiology.

Much is made today of unfavorable life experiences as preparing the soil for the development of a psychosis. Meyer, in an example of his psychobiologic concept of the life picture, depicts the development of a child, during which her growth is punctuated by the mental traumata of a fright, the onset of menses for which the child was unprepared, an older sister being favored by the father, an unhappy love affair, and, finally, the appearance of a psychosis. This history may, with equal logic, be interpreted organically. Is it not possible that some intrinsic mental defect was present in the child which was the cause of her father favoring an older sister, which was the cause of an untoward reaction to the onset of menses and the cause of an unhappy love affair, and which finally manifested itself as a frank psychosis?

It is generally recognized and accepted that environmental stress bears a relationship to such clinical conditions as peptic ulcer, colitis, and vascular disturbances. These are frequently held up as an example of environment producing organic disease. To the question of why, then, do not similar psychic traumata produce similar disease in all individuals, the answer is given that the reaction of any individual is specific for him and dependent upon his personality make-up. Is it not possible for the patient who reacts unfavorably to environmental stress to be possessed of an intrinsic organic defect, possibly genetic, which makes him thus react? One might even call it "personality make-up" providing the possibility of its being of an organic nature is not rejected.

Different schools of thought on any subject encourage mental gymnastics in support of one or the other. The *post hoc, propter*

hoc school of thoughts is very common. We are confronted with a group of symptoms which fall into the syndrome called dementia præcox. We then dig back into the life-history of the patient and come up with numerous examples of "mental traumata" and unfavorable environment which we hold up as evidence of "environmental stress." Our next step is to look for a precipitating factor. This is not too difficult. The most recent episode of environmental stress becomes the precipitating factor. One more factor is needed to complete the diagnosis, a susceptible individual. This is easiest of all since obviously anyone who becomes ill is, of necessity, a susceptible individual.

We have now neatly pigeon-holed a case of schizophrenia; and there is a good likelihood that the patient will now be subjected to convulsive shock therapy, which is essentially the use of an unknown modality to treat a disease of unknown etiology.

In conclusion it must be stated that the mere fact that histologic studies reveal no demonstrable brain pathology in schizophrenia, does not mean that none exists. The fault probably lies with our methods of study, which are rather gross and which utilize techniques which for the most part have remained unchanged throughout the years.

The foregoing paragraphs undoubtedly represent an oversimplification of the problems involved and are, perhaps, unduly pessimistic. However, there is some encouraging work being done today which departs from the routine sectioning and staining of the brain and the oft-repeated studies of the blood chemistry—both of which procedures have been rather sterile of results, particularly the latter. The geneticists are supplying some valuable information, and studies directed toward the colloidal structure of the brain may prove fruitful. In short there is much indication that further clarification of etiology and pathogenesis, from an organic standpoint, may be forthcoming in the not too distant future.

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THE PHYSIOLOGY OF HYPNOSIS. II.*

A Review of the Literature

BY BERNARD E. GORTON

Physiology of the Gastro-Intestinal System in Hypnosis

The majority of studies dealing with the gastro-intestinal system in the hypnotic state are concerned with the physiological changes which can be brought about through hypnotic suggestion of sham feedings or of emotional states capable of modifying gastro-intestinal activity. The studies of Wolf and Wolff (1943) have placed the concept of psychosomatic interaction on a sound experimental basis so far as the gastro-intestinal system is concerned.**

Pavlov's work on the psychic influencing of gastric functions has been quite basic in that respect, for it seems that nothing is more convincing than to be able to state that a given experiment with human subjects agrees with the findings on dogs made by Pavlov and his associates.

Heyer (1923) investigated fluoroscopically the influence of hypnotic suggestion on gastro-intestinal motility in four patients suffering from constipation and visceroptosis. By means of suggestive removal of the symptoms he was able to obtain considerable changes in the time required for digestion of a meal, to increase peristalsis, and to lessen tonic spasticity of the gut. Suggestions to the effect that the symptoms would become exacerbated were also effective. Controls were run in the hypnotic state without suggestions, and it was noted that defecation occurred considerably earlier in those subjects who had been given suggestions of symptom removal, even though defecation was never suggested as such.

*This is Part II of a two-part paper on the physiology of hypnosis. It covers the physiology of the gastro-intestinal system, kidney function, and muscular and reflex activity during hypnosis; pharmacological aspects of hypnosis; hypnotic anesthesia; hypnosis in psychosomatic research; physiological changes associated with hypnotic age-regression; a conclusion and bibliography. Part I, covering a general introduction, notes on theories and methodological problems, and discussion of the electroencephalogram, metabolism, respiration, circulation, vasomotor activity and hematological changes during hypnosis, appeared in the April 1949 issue of The Psychiatric Quarterly.

**It is significant comment on the status of hypnosis in physiological research that such "psychosomatically-minded" authors as Wolf and Wolff cite only one study of gastric function under hypnosis, despite the existence of a considerable number of such investigations.

A subject which has received much attention is the influence of hypnotic suggestion on gastric hunger contractions. Scantlebury (1940) noted that suggestions of eating given in a light hypnotic trance were capable of inhibiting hunger movements. Suggestions of eating or the sight of food did not inhibit hunger contractions in the waking state. Scantlebury and Patterson (1941) found that when a sham feeding was suggested during the period of gastric activity there was always some inhibition of the hunger contractions, except in the period of tetany. The effect of the suggestion of eating a sham meal was found to vary, depending upon when in the period of contractions the suggestion was made. A meal suggested in the first two-fifths of a hunger period resulted in a temporary inhibition of gastric movements, whereas a meal suggested in the second three-fifths of the normal hunger period brought about a complete cessation of gastric motility which then continued on to a normal quiescent period.

Scantlebury, Frick, and Patterson (1942) found that hypnotically-induced dreams, with food as an integral part of the dream, inhibited gastric hunger contractions, and they suggest that the dream may affect the cephalic phase of gastric secretion which then in turn causes decreased contraction of the stomach. The findings of Scantlebury and his associates have been confirmed by Lewis and Sarbin (1943) who performed experiments on eight subjects to determine the influence of hypnotic suggestion on hunger contractions. These authors observed that if a fictitious meal was suggested, the results obtained were similar to those seen in a hungry person in the waking state who partakes of real food—in that gastric hunger contractions are inhibited and a feeling of satiety is evoked. An important observation made by Lewis and Sarbin is that the gastric hunger contractions are inhibited most frequently in the deeply hypnotized subjects, less frequently in the moderately hypnotized subjects, and not at all in the non-hypnotized subjects. This experiment is the only one known to the present author in which the depth of hypnosis was determined quantitatively.*

The cephalic phase of gastric secretion which has been investigated so successfully in experimental animals by means of the

*The Friedlander-Sarbin (1938) scale of hypnotizability was used by these authors. While by no means universally accepted, this scale permits quantitative estimation of the depth of hypnosis.

Pavlov Pouch can be studied in the human subject by means of the technic of hypnotic suggestion. A pioneering study is that of Bennett and Venables (1920) who noted the effects of various emotions on gastric secretion in the hypnotic state.* More satisfactory from an experimental standpoint is the work of Luckhardt and Johnston (1924) who investigated the psychic secretion of gastric juice under hypnosis. An important discovery made by these authors is that the induction of hypnosis alone results in a secretion curve as high in acidities as can be obtained by any other method.** After the spontaneous rise in acidity because of the induction of hypnosis had subsided, the suggestion of food caused an additional rise in acidity comparable to that when the test meal is actually given. Conversation concerning food in the waking state was also found to cause a psychic secretion of gastric juice which was comparable to that obtained by means of hypnotic suggestion. Since these authors did not analyze their data statistically, it is not possible to say whether hypnotic or waking suggestion was more effective in stimulating gastric secretion.

The influence of emotions on gastric acidity has been studied by Heilig and Hoff (1925) who suggested to a group of subjects that they were eating—at one time with great enjoyment and at another time with strong disgust—a given food (to which they ordinarily had no particular reaction). Suggested enjoyment was found to increase acidity, whereas disgust was associated with a decrease in acidity which was much more marked than the increase produced by enjoyment. In another series of experiments these authors suggested the ingestion of a food to different subjects one of whom normally exhibited an unconquerable aversion to it while the other considered that particular dish a favorite. Suggestion of a favorite food was found to result in hyperacidity, but the suggestion of the identical food to a subject who disliked it caused a hypochlorhydria, and this occurred even if the suggested food was ordinarily considered to be a secretagogue (e. g., fried onions). This experiment appears to demonstrate that the nature of gastric secretion is not in all cases specific for a given

*This study is distinguished by citation in Best and Taylor (1943, p. 432).

**Hull (1933, p. 279 n.) suggests that this secretion following the induction of hypnosis may be due to a conditioned response acquired by the subject following previous hypnosis in which food was suggested.

food but is dependent at least to some degree on the attitude of the individual toward the food.

The researches of Pavlov and his co-workers indicate that the quantity and properties of the gastric secretion vary according to the character of the food ingested. Heyer (1925) was able to confirm these results on human subjects who had been hypnotized and received suggestions of the intake of different foods. Under deep hypnosis, a stomach tube was introduced (the subject being unaware of the nature of the experiment), the fasting stomach contents pumped out, and, if no secretion was found to have occurred after 10 minutes, suggestions of the ingestion of a cup of meat broth, a slice of bread, or a glass of milk were given on different occasions. Swallowing of saliva was prevented, and the gastric juice was collected at five-minute intervals and examined for quanity, acidity, and proteolytic activity. The absolute quantity of juice appeared to correspond to the vividness of the suggestion as received by the subject. The secretion curves obtained in this manner were found to be characteristically different according to the nature of the food which had been suggested, just as in Pavlov's findings with his dogs. Langheinrich (1922) employed the same technic in studying the effect of the suggestion of butter intake and found that the human stomach responds specifically to the suggestion of fat. In a second series of experiments in which a tube was introduced into the duodenum Langheinrich observed that the secretion of bile also responds quantitatively and qualitatively to the suggestion of butter as compared with the suggestion of meat broth. Mechanical irritation of the duodenum as a chief factor in bile secretion was ruled out in a control series in which no suggestions of food were given; a small amount of bile was secreted, but considerably less than that resulting from the suggestions of fat or meat broth.

The specificity of pancreatic secretion in response to different foods has been demonstrated in dogs.* Delhougne and Hansen (1927), using a technic similar to that of Heyer, were able to show that suggestion of protein foods led to an increase in the secretion of pepsin and trypsin, that suggestion of fatty foods caused an increased secretion of lipase, and that suggested carbohydrate intake led to an increase in maltase. In every case the secretion of these enzymes was specific, and the enzyme activity was found

*Cf. Fulton (1947, p. 1063).

to correspond to that found when these same enzymes were secreted in response to actual feeding of the foods in question.

The literature which has been reviewed indicates that gastric hunger contractions can definitely be inhibited by hypnotic suggestion of food intake and that such inhibition cannot be accomplished in the waking state. Gastric secretion seems to respond to both waking and hypnotic suggestion, but the relative effectiveness of these stimuli is not clear. The specificity of gastric and pancreatic secretion in response to the suggested intake of different foodstuffs under hypnosis appears to be well established and seems to correspond to the selectivity of secretion observed in dogs. That emotions are capable of affecting gastric activity in hypnosis as well as in the waking state is apparent, and this observation is significant in view of the high incidence of functional gastro-intestinal disturbances. The effect of hypnotic suggestion in modifying gastro-intestinal function is more clearly established than similar effects upon any other organ system in the body, and the changes thus produced agree well with the results of animal experimentation and the observations of clinicians concerning the importance of psychosomatic factors in the etiology of gastro-intestinal illness.

Kidney Function in Hypnosis

Only a few renal function studies in hypnosis are to be found in the literature; and, since they antedate the introduction of clearance methods into renal physiology, they are unsatisfactory from a methodological standpoint. Heilig and Hoff (1925) investigated the effect of hypnotically-suggested emotions on the excretion of water, sodium chloride, and phosphate. Ten normal subjects, whose fluid intake had been fixed at 1,800 cc. on the day preceding the experiment, received 1,000 cc. of tea in the post-absorptive state; and their urine output was measured and analyzed for NaCl and phosphate content during the succeeding hours while they were subjected to suggestions of pleasant or unpleasant feelings. The NaCl intake of the nurses who served as experimental subjects was controlled by placing them on a salt-free diet prior to the experiment. From the data obtained Heilig and Hoff conclude that pleasant feelings were effective in reducing the excretion of water, NaCl and phosphate, whereas unpleasant feelings exerted a diuretic action and also increased the chloride and phosphate ex-

cretion, not only absolutely through the increased urine flow, but also relatively. The data presented by these authors show fairly close agreement in the cases of all 10 subjects, and it is unfortunate that it is not suited to analysis according to the clearance method. Heyer and Grote (1923) are said to have found an increased excretion of phosphate under emotional influence in hypnosis (their original study was not available to the present author). Hoff and Wermer (1926) investigated the anti-diuretic action of pitressin in the hypnotic state and found it to be abolished during hypnosis. Control experiments are said to have shown the subject's response to pitressin in the waking state to be normal. That the suggested intake of water under deep hypnosis is capable of producing a diuresis of lowered specific gravity is reported by Marx (1926). This study has not been repeated and remains unconfirmed.

On the whole, studies of renal function under hypnosis are marred by an absence of what would today be considered indispensable data in such investigations. Until such time as clearance methods are applied to these problems, we must reserve our opinion concerning the effects of hypnotic suggestion on renal function.

Muscular Activity During Hypnosis

Startling claims concerning the transcendence of voluntary motor capacity in the hypnotic state have been made by the older authorities. Hull (1933) has reviewed this literature and finds it to be characterized by a lack of quantitative data, which is typical of most of the early work on hypnotic phenomena. Muscular catalepsy was long considered an infallible criterion of the hypnotic state, and this view is still frequently encountered in the literature, especially in the writings of the Russian reflexologists who adhere to the theory that hypnosis in human beings is identical with the state of tonic immobility which can be induced in animals ("animal hypnosis").* Hull has demonstrated that catalepsy is easily induced in the waking state and that it is therefore not an adequate criterion for hypnosis. A careful study by Williams (1930) revealed that no significant differences existed in the rate of arm descent and tremor during catalepsy in the trance and the non-trance state. Of interest is the fact that Williams' subjects

*Cf. Liberson (1948) and True (1948).

suffered a good deal of pain in their arms during the waking experiments but none whatever under hypnosis.

In an investigation of resistance to ergograph fatigue during hypnosis, Nicholson (1920) found that "during hypnotic sleep the capacity for work seemed practically endless" and in his original article he shows ergograph tracings which appear to substantiate this view. One of Nicholson's experiments consisted in letting the subject work to practical exhaustion in the non-trance state and then suddenly put him under hypnosis without interrupting the work. The tracings indicate that the amplitude of the lift returns almost to the original level and continues at this level without perceptible diminution for six minutes. A control experiment in the waking state in which the subject again worked until practical exhaustion and then was given the same suggestions of encouragement as previously, the only difference being that he was not hypnotized, shows that although a slight rise in lifts and a marked increase in duration occurred, this was not remotely comparable to that resulting from the same suggestions during hypnosis. Williams (1929) studied the effect of waking and hypnotic suggestion on muscular work by a similar technique and observed a mean increase of work amounting to 12.4 per cent (critical ratio of 4.46). These results under hypnosis as compared with the waking state (obtained from five subjects) confirm Nicholson's results qualitatively in showing the trance to possess a heightened susceptibility to suggestion to abolish the effects of muscular exhaustion. Young (1925, 1926), in a controlled investigation of hypnotic suggestion and the strength of grip, found the averages of the grip scores for 12 subjects (616 measurements) to be exactly alike in the trance and non-trance states.

In discussing the experiments just outlined, Hull (1933) concludes that the hypnotic state *per se* is incapable of producing supernormal capacity as to muscular power and resistance to fatigue. He feels, however, that the data justify the conclusion that in hypnosis the state of heightened suggestibility is such that performances beyond the usual voluntary range can be induced, provided the proper suggestions are given, and he explains this on the basis that the effects of fatigue and pain are minimized by the suggestions. The problem of supernormal muscular activity under hypnosis would thus appear to be essentially a question of a selective

anesthesia for pain and fatigue which is induced in the subject by means of suggestions which increase his motivation.*

Reflex Activity in Hypnosis

The classical investigation of reflex activity during hypnosis is that of Bass (1931) who studied the patellar reflex in sleep and hypnosis. It is well known that certain reflexes show very marked reduction or even complete abolition during sleep, and Bass took advantage of this fact to demonstrate conclusively for the first time that hypnosis and sleep are not identical—a question concerning which confusion had existed for over a century and a half. Bass demonstrated that while the patellar reflex is very considerably inhibited during sleep, it responds to stimulation in hypnosis in a manner quite similar to that observed in the waking state. This investigation is eminently satisfactory from every point of view, and can be regarded as definitive in its results.

The facility with which conditioned reflexes are acquired during the hypnotic trance has been studied by Scott (1930) who finds that not only are conditioned responses acquired in hypnosis, but that they are acquired with greater facility than in the waking state. These results are confirmed by Mishchenko (1935) and by Leuba (1941) who finds that conditioned responses (usually difficult to produce in human adults in the laboratory) are formed more readily under hypnosis. The effect of a posthypnotically-induced auditory anesthesia (deafness) on a conditioned patellar reflex in which the conditioned stimulus was the sound of a bell was investigated by Fisher (1932). This author found the posthypnotically-induced deafness to be effective in inhibiting the conditioned response. Erickson (1938) has reported similar results with hypnotically-induced deafness.

Lundholm (1928) has reported observations to the effect that hypnotically-induced dysfunctions of various kinds are not associated with any modifications of reflexes. Thus a subject in whom a complete functional blindness has been induced by hypnotic suggestion will react to light with a perfectly normal contraction of the pupils; similarly, a subject who experiences a hypnotically-induced hallucination of strong light will not present any contrac-

*Such temporary heightening of capacity to perform work as the result of any stimulation of an emotional character has long been known to investigators in the field of work and fatigue, according to Hull.

tion of the pupils when the signal initiating the hallucination is given. Dorcus (1937) has confirmed the findings of Lundholm with respect to the inability of hypnotic suggestion of light to affect the normal pupillary reflex. This author also finds the nystagmus response and the falling reaction to be uninfluenced by hypnotic suggestion of rotation; an interesting finding was that the subjects did not fall if rotation was suggested at first, but following an actual rotation in the Barany chair the same subjects fell when rotation was suggested a second time, but in the "wrong" direction since they did not know the laws governing the falling reaction. Dorcus concludes that the hypnotized subject attempts to the best of his ability to act in the manner which he feels is expected of him, but that he is unable to make the proper response if he does not know what he is "supposed to do."

From the studies reviewed here it appears that the process of hypnosis *by itself* does not alter the normal waking reflexes (e. g., knee jerk). It appears to have been shown that conditioned responses are more readily acquired in the hypnotic than in the waking state. The authors cited were unable to produce modifications in the pupillary and vestibular reflexes by means of hypnotic suggestion. But others have succeeded in inhibiting a conditioned response to an auditory stimulus by means of hypnotically-induced deafness. Moreover, it has recently been demonstrated that the normal plantar flexion response to stimulation of the sole of the foot can be changed to the "pathologic" dorsiflexion response (Babinski's sign) through hypnotic age-regression.* In summarizing the evidence concerning reflex activity in hypnosis, then, we find that it is contradictory to the extreme. Thus we find that some authors report the most profound alterations of reflex physiology, while others obtained no results whatsoever. The present author does not feel that we are in a position to "explain" these paradoxical results at the present time. He can only suggest that repetition of the various experiments with close attention to the technics of hypnotic induction and the subjects employed, as well as standardized methods of suggestion and adequate controls in the trance and waking state are bound to disclose the reason for the widely varying results and to throw light upon the mechanisms involved.

*For details of changes in the plantar response under hypnotic age-regression, the reader is referred to the appropriate section of this paper.

Pharmacological Aspects of Hypnosis

It has long been the belief of hypnotists that the use of such drugs as morphine, alcohol, ether, chloroform, chloral, hashish, and various bromides facilitates the induction of the hypnotic trance in refractory cases. From the clinician's standpoint, it would be useful to have available pharmacological means of inducing hypnosis in those subjects with whom verbal technics do not prove successful; one of the chief arguments advanced against the use of hypnosis clinically being the contention that not all patients prove to be successful subjects. The influence of drugs upon suggestibility, therefore, becomes a matter of more than academic interest.

In considering the question of the role of drugs in facilitating the induction of hypnosis it is necessary to keep in mind the distinction between hypnosis and the altered states of consciousness which can be brought about by certain drugs. Kubie (1943) has reviewed the various drugs which have been used to induce hypnagogic states which permit the uncovering of the unconscious aspects of the personality. While these states and their induction ("narcosynthesis") bear many resemblances to hypnosis in that they permit the recovery of buried memories, revivification of past experiences, and the general uncovering of unconscious processes, they do not necessarily fulfill Hull's criterion of hypersuggestibility, and it is therefore not justifiable to place them under the heading of hypnosis. Our present knowledge of the nature of hypnosis and related hypnagogic and hypnoidal states is as yet too inadequate to admit of a precise classification. It is important to note, however, that an interrelationship exists between hypnosis induced by verbal means and the twilight states of consciousness produced by such substances as sodium amytal, pentobarbital sodium, scopolamine hydrobromide, and pentothal sodium. It has been found that subjects who prove refractory to the induction of hypnosis may be rendered more susceptible by being placed in a hypnagogic state by the use of one of the aforementioned drugs and then being instructed that they would enter a similar state the next time the operator attempted verbal hypnosis (Wolberg, 1948). It is thus possible to make available for hypnosis a large number of individuals who are not readily hypnotized by the verbal technic and to avoid dependence upon what Hadfield (1942) terms "the more

mechanical methods." The fact that drug hypnosis may be utilized to facilitate verbal hypnosis indicates that an interrelationship exists between the psycho-physiological states involved.

A few quantitative experimental studies of the effect of drugs on suggestibility and, therefore, by implication upon hypnotizability, are available. Hull (1933) finds that the influence of alcohol upon heterosuggestion, as measured by his postural sway technic, is slight. Baernstein (1928) investigated the effect of scopolamine hydrobromide upon suggestibility and found a heightened susceptibility to suggestion in all of the eight normal subjects studied. Her study is of significance, not only because of the exact quantitative and statistical treatment of the data, but also because scopolamine hydrobromide is one of the drugs which has been used clinically for purposes of narcosynthesis. It appears probable that all of the drugs listed by Kubie may well prove to have a direct effect upon suggestibility. Such a finding (as yet unavailable) would indicate that the processes of narcosynthesis and hypnosis are related in that both involve a factor of hypersuggestibility.

Wilson (1927) reports that by the breathing of a mixture of nitrous oxide and air, nitrous oxide and oxygen, "a perfectly suggestible state may be produced without loss of consciousness." Wilson finds that the proportion of nitrous oxide and oxygen required to produce hypersuggestible states varies in different individuals and that "perfect suggestion phenomena are easily obtainable."

Evidence is available that the hypnotic state, in turn, may be capable of influencing the effects of various drugs. Sumbajew (1935) finds that alcohol, choral hydrate, morphine, and barbital had a much stronger effect used in conjunction with hypnosis. This author claims to have succeeded in being able to counteract the action of barbital, chloral hydrate, and alcohol. Platonow and Matzkewich (1931) gave mental performance tests to two normal subjects, first, while they were intoxicated, and later after they were hypnotized. The scores were much lower than normal after the alcohol but returned to normal levels as the result of hypnosis. In another experiment by the same authors the subjects received intoxicating doses of alcohol while hypnotized but were told that they were drinking water. It is stated that they showed no signs of intoxication in the post-hypnotic state and performed at their

normal levels. Shliffer (1930) investigated the effect on the blood pressure of injecting adrenalin during "experimental sleep" (i. e., hypnosis). It was found that "injections of 1 cc. of 1 per cent adrenalin solution in six subjects increased their blood pressure by 24-58 divisions on a Riva-Rocci instrument when the subjects were in a normal state, but failed to produce any change or gave an increase of only 4-10 divisions when the same subjects were put under hypnosis.* The experiments reported in the foregoing have never been confirmed in this country, but it is only fair to state that no one has attempted to duplicate them. While Shliffer's results appear extraordinary, they are not any more so than certain other hypnotic phenomena that have been confirmed. Certainly the investigations of Sumbajew, and Platonow and Matzkewich would bear repetition under controlled conditions.

Hypnotic Anesthesia

The subject of hypnotically-induced anesthesia or, more precisely, analgesia, represents one of the most fascinating aspects of hypnotism, and one which has long attracted the attention of investigators. It is interesting to recall that in 1845 hundreds of operations were performed in India by a British surgeon named James Esdaile during which the patients were under the influence of hypnotic anesthesia. This aid to surgery attracted considerable attention at a time when chemical anesthetics had not yet come into use, and even today the use of hypnosis for inducing painless childbirth is recommended by some obstetricians.** The spectacular nature of this aspect of hypnosis lends especial interest to the results of controlled laboratory experiments, particularly in view of the claims of such earlier workers as Esdaile who asserted that during his operations under hypnotic anesthesia the patients not only remained perfectly quiet but failed to show the ordinary physiological signs of pain, such as changes in pulse rate, respiration, and dilatation of the pupil.

The physiological variables which have been studied during hypnotic anesthesia in the laboratory include the galvanic skin reaction ("psychogalvanic reflex"), heart rate, facial flinch, respiratory changes, and vasomotor reactions. One of the earliest ex-

*This article was seen only in abstract.

**An interesting discussion of the advantages, from a clinical standpoint, of hypnotic as opposed to chemical anesthesia is given by Hollander (1932).

perimental studies of hypnotic anesthesia is that of Levine (1930b) who investigated the psychogalvanic reflex in two subjects, one of whom could be placed in a deep hypnotic trance, the other subject possessing a profound spontaneous (hysterical) anesthesia of the arms and legs. In another study of six psychiatric patients Levine (1930a) found that the induction of hypnosis does not materially alter skin resistance, either when that resistance is within normal limits or when it is beyond normal limits. Levine also noted that palmar skin resistance is increased in normal sleep and is not increased in hypnosis. From his studies of the psychogalvanic reaction to painful stimuli in hypnotic and hysterical anesthesia, Levine was led to conclude that no dissociation occurred between painful stimuli and the normal electrical skin reaction observed under such stimulation in either hypnotic or hysterical anesthesia, even though both were effective in removing overt responses to pain. Hull (1933) points out that Levine, like his predecessors in the field, appears to have been looking for an all-or-none relationship and failed to make systematic measurements to determine whether the anesthetic condition might not have been associated with a certain amount of weakening of the galvanic skin response. We are fortunate to have a study by Sears (1932) in which objective measurements were made and the data subjected to statistical treatment, allowing a convincing comparison to be made between an experimental anesthetic series and its normal control. Employing as subjects seven male university students who were capable of deep trance, as shown by profound analgesia and post-hypnotic amnesia, Sears studied the facial flinch, respiratory movements, cardiac activity, and the galvanic skin reaction by means of an elaborate recording system. The left leg was used for the study of hypnotic anesthesia, the right leg being employed as a non-anesthetized control. Sears' results are of considerable importance,* and may be summarized as follows: 1. The facial flinch and the increased oscillation and variability in the respiratory tracings are practically eliminated by hypnotic anesthesia. 2. Hypnotic anesthesia is capable of reducing to a considerable extent the increased variability which is characteristically found in the pulse tracing following a painful stimulus. 3. The gal-

*Inspection of Sears' original data shows that in all cases except that of pulse oscillation the statistical reliability of the difference between the anesthetized and the control leg has a critical ratio of practically 3 or above.

vanic skin response shows a mean reduction of 20 per cent on the anesthetic leg. 4. That hypnotic anesthesia is in any way a conscious simulation seems doubtful. Voluntary inhibition of reaction to pain does not present a picture even remotely resembling the reaction under hypnotic anesthesia. (Results of separate waking control series.)

With the general fact of a positive influence of hypnotic anesthesia before us, we are in a position to consider the relation of the volitional character of the several reactions to the magnitude of this influence. The results of Sears' investigation are summarized from this point of view in the accompanying table.

Summary of the Percentage of Mean Reduction in the Amounts of Various Reactions to Pain Presumably Due to Hypnotically Suggested Anesthesia*

Volitional character of reaction	Reaction	Percentage of mean reduction on anaesthetic leg
Wholly voluntary	Verbal report	95**
Partially voluntary	Facial grimace	92
Partially voluntary	Respiratory oscillation	105
Partially voluntary	Respiratory variability	109
Non-voluntary	Pulse, oscillation	77
Non-voluntary	Pulse, variability	50
Non-voluntary	Galvanic skin reaction	22

*Reproduced from Hull (1933, p. 264).

**Estimate given by Dr. Sears in a private communication.

It appears that the reactions classed as wholly and as partially voluntary are approximately alike in the extent of the diminution of the reaction as the result of suggested anesthesia. The three measures classed as non-voluntary present an appreciably smaller amount of reduction. These results agree in a general way with the hypothesis that hypnotic suggestion is operative to a considerable extent on the volitional level, but the fact that both pulse and the galvanic skin reaction show very appreciable effects points to some other and more deep-lying mechanism as also operative. This conclusion is strengthened by the fact that Sears undertook two control series in which the subjects in the normal waking condition were instructed to repress or conceal, as far as possible, all reactions to pain. The results clearly indicated that voluntary in-

hibition of reaction to pain does not present a picture even remotely resembling the reaction under hypnotic anesthesia.

A study of hypnotic anesthesia by Dynes (1932) disclosed that respiration and cardiac activity show little or no disturbance in their normal rate and rhythm following painful stimuli in hypnotic anesthesia while these same indicators invariably showed a disturbance during stimulation in the waking state. The psychogalvanic reflex was little influenced in the hypnotic trance, a slight decrease, as compared with the normal controls, being noted under hypnotic anesthesia following sensory stimulation. The usual gross responses to pain were invariably inhibited in the hypnotic trance. It will be noted that the results obtained by Dynes agree well with those reported by Sears.

Brown and Vogel (1938) carried out a comparative investigation of hypnotic anesthesia and nitrous oxide anesthesia. Using three subjects capable of deep hypnosis characterized by post-hypnotic amnesia and anesthesia, quantitative changes in blood pressure, heart rate, respiration, and skin potential were recorded by means of the Darrow Photopolygraph. The most remarkable finding of Brown and Vogel is that "quantitative changes in physiological reactions to painful stimuli are not reliable indicators of painful experience." Since these authors failed to submit their data to statistical analysis it is difficult to evaluate their conclusion that "suggested analgesia in the hypnotic state does not abolish physiological reactions to sensory stimuli." It is not surprising that Brown and Vogel found that gas anesthesia is not comparable to hypnotic anesthesia, since the former induces a marked change in the physiological state which is quite dissimilar to that observed during hypnosis. The caution necessary in interpreting the physiological effects which result from painful stimulation is exemplified by Brown and Vogel's observation that imagination in the waking state may be just as effective with respect to the influencing of the physiological reactions to pain as that which may be noted following suggestion in the trance state.* Moreover, it was found that hypersensitivity suggested during hypnosis is capable of markedly increasing the physiological reactions to sensory stimulation.

*Levine (1930b) found that a hypnotically-induced hallucination of being stuck with a needle was capable of producing a psychogalvanic response.

In the opinion of the present author, from a statistical point of view, the work of Brown and Vogel is not sufficiently detailed or satisfactory to constitute a serious objection to the results obtained by Sears (1932) and confirmed by Dynes (1932). Whether the finding that quantitative changes in physiological reactions to painful stimuli are not reliable indicators of painful experience, which is in strong contrast to the results of Sears and Dynes, is due to discrepancies in experimental technic or is traceable to individual differences in the experimental subjects, is impossible to decide from the data available. It would certainly appear that further work is required to elucidate clearly the relationship between painful stimulation, suggestions of painful stimuli, various emotional states, and changes in such physiological variables as cardiac activity, respiration, and skin potential.

The complexity of the variables encountered in a study of hypnotic anesthesia and the fact that the nature of the stimulus is in itself a determining factor of the resulting physiological response is well illustrated by the work of Doupe, Miller, and Keller (1939) who studied vasomotor reactions in the hypnotic state. These authors conclude that "the hypnotic state itself did not change the state of the peripheral circulation, nor did it significantly alter the vasoconstrictor response to a painful stimulus." Recording changes in digit volume and respiratory movements photographically in a manner that permitted of precise quantification of the data, Doupe et al. then proceeded to measure the effects of moderate and severe painful stimuli in the form of pinpricks and prolonged application of ice to the skin. A decrease in the amount of vasoconstriction in response to painful stimulation was found to occur under hypnotic anesthesia. The surprising finding was made that while vasoconstriction decreased by an average of 12.1 per cent following *moderate* pinpricks under hypnotic anesthesia, *severe* painful stimuli under the same conditions were accompanied by a decrease of 27.1 per cent in vasoconstriction as compared with the vasoconstriction resulting from the same stimulus on the control (non-anesthetic) limb. It was also noted that repeating the suggestion of anesthesia was important in obtaining optimal results. Reinforcement of the suggestions of anesthesia increased the difference in vasoconstriction from +13 per cent to —40 per cent and was thus obviously a factor in the degree of inhibition of vasoconstriction obtainable by means of hypnotic anesthesia.

Doupe and his associates also found that hypnotic anesthesia was successful in abolishing grimacing; they were unable to find any significant changes in the pulse tracings. A slight alteration in the respiratory rate occurred when both normal and anesthetic limbs were stimulated, but the alteration tended to be greater following stimulation of the normal limb.

The work of Doupe and his associates is important in that it demonstrates that hypnotically-induced anesthesia is capable of inhibiting the vasoconstrictor response to painful stimuli to approximately the same extent that Sears found the psychogalvanic skin response to be inhibited, i. e., a reduction of 27 per cent and 22 per cent, respectively. This evidence indicates that physiological reactions which are ordinarily not under voluntary control are inhibited by hypnotic anesthesia. The abolition of the facial flinch and the relatively slight changes in the pulse and respiration under hypnotic anesthesia are findings upon which all investigators except Brown and Vogel agree. It must be concluded that a sound physiological basis has been demonstrated for the phenomena of hypnotic anesthesia, although the precise nature of the mechanisms involved remains obscure.*

Hypnosis in Psychosomatic Research

Because of the ease with which various emotional states can be produced in the hypnotic subject by appropriate suggestions, hypnosis provides an excellent means for investigating the relation of emotions to bodily changes. Hypnosis provides the investigator with a means for controlling the emotional variable in his subjects at will and makes possible the study of the physiological effects of various emotional states under experimental conditions. In view of these evident advantages of the use of hypnosis in the investigation of psychosomatic problems, it is surprising to find that the hypnotic technic has not been more widely employed in studies of this kind. This observation reflects the suspicion with which hypnosis is still regarded by many scientists and the large amount of misconception and ignorance which still prevails concerning this subject. Our knowledge of hypnosis and the physiological mech-

*Wolff and Goodell (1943) report that "shallow hypnosis" raised the pain threshold 40 per cent, as measured with the Wolff-Hardy-Goodell thermal stimulating apparatus. Waking suggestion through placebos produced a pain threshold-raising effect of some 30 per cent.

anisms involved in its production is at present limited; but this constitutes no serious objection, for the same criticism may be applied to all the other psychological variables which are of necessity involved in a study of psychosomatic interrelationships. Since it has been clearly shown that hypnosis does not differ significantly from the waking state so far as physiological criteria are concerned, the physiologist need not fear that the introduction of hypnosis into an experiment will invalidate the physiological data obtained. It is true that no adequate means are presently available to quantitate emotional factors, but this criticism is one that applies to emotions in the waking as much as in the hypnotic state. The greatest problem in an investigation of psychosomatic phenomena at present is that of controlling and measuring psychological variables; and it is in the control of these variables that hypnosis proves most effective.

To illustrate the possibilities of the use of hypnosis in studying the pathogenesis of psychosomatic disorders, a series of experiments performed some 25 years ago by Deutsch and Kauf (1923) may be cited. These authors attempted to show that ideas and experiences originally accompanied by anxiety are capable of causing cardiovascular disturbances even after anxiety is no longer consciously associated with them. A disturbing experience was suggested to a subject under hypnosis, together with the post-hypnotic suggestion that in the waking state a certain signal (the seemingly accidental dropping of a handkerchief) would cause the subject to re-experience the same emotions without being consciously aware of it. Complete amnesia for the hypnotic session was then induced. When, after hypnosis, the handkerchief was dropped there was a definite increase in the pulse rate in all the subjects studied. Two subjects who had in addition been given the suggestion that on the dropping of the handkerchief they would remember the experience completely and re-experience the emotion consciously showed only a negligible increase in heart rate. This shows, according to the authors, that unconscious, not abreacted, experiences are capable of maintaining a somatic disturbance, whereas the symptom subsides once the causative experience has become conscious and its corresponding affect abreacted.

Wolberg (1947) reports a series of cases in which experimental conflicts induced under hypnosis resulted in psychosomatic symptoms which could be traced directly to the conflict, and which dis-

appeared when the conflict was removed. Thus it was suggested to one subject that upon awakening from the trance he would experience an irresisible desire to pick up a candy bar lying on a nearby table, but that he would have an equally strong feeling that it would not be proper for him to do so and that he would therefore feel unable to follow his impulse. Upon awakening, the subject became restless, glanced frequently in the direction of the table, and finally complained of a headache the cause of which he was unable to explain. Removal of the conflict in a subsequent hypnosis abolished the headache. Among the symptoms reported by Wolberg as having been produced in this manner are dizziness, tachycardia, muscular tremor, nausea, vomiting, a "generalized autonomic disturbance," and hysterical blindness.* It is conceivable that the important problem of the "choice of organ" in the formation of an organ neurosis may be successfully investigated by this or a similar technic, and that an answer may be supplied situation develops cardiovascular symptoms while a different patient responds to the same situation with gastro-intestinal symptoms. It is the conviction of the present author that much valuable work remains to be done in this field, and that the use of hypnosis to produce unconscious emotional conflicts in the laboratory is a promising research tool for the investigation of psychosomatic illness.

Physiological Changes Associated with Hypnotic Age-Regression

It is possible during hypnosis to create a state of disorientation with respect to place, person, and time. The phenomena which result when an individual is thus returned to earlier periods in his life are considered due to "hypnotic age-regression" and have been the subject of much argument ever since Krafft-Ebing's original experiments. Considerable disagreement exists at present as to the question why one patient in response to a given emotional to whether hypnotic age-regression is actually a recapitulation of a previous stage of development, or whether the subject merely re-enacts an earlier developmental stage on the basis of his present-day concepts of what a person at the suggested age level is supposed to do. It is not possible here to review the data and

*Other experiments demonstrating psychosomatic interrelations are those of Erickson (1943) and Bitterman and Marcuse (1945).

conclusions of the various investigators who have studied the problem. The reader is referred to the work of Platonow (1933), Bergman, et al. (1947), Spiegel, et al. (1945) and of Erickson and Kubie (1941) for evidence which purports to show the "genuine" nature of hypnotic age-regression. Young (1940) is convinced that hypnotic age-regression is an "artifact." Wolberg (1948) and Gidro-Frank and Bowersbuch (1948) present good discussions of the conflicting psychological and clinical evidence bearing on this problem. These authors agree that regression actualiy does reproduce behavior of earlier developmental periods in a way that obviates all possibility of simulation. Recently there have appeared in the literature several reports of physiological changes during hypnotic age-regression which substantiate this viewpoint.

It is well known that the normal adult response to plantar stimulation is plantar flexion. The most important response to plantar stimulation is dorsiflexion of the great toe which, with certain other reflex phenomena, constitutes the Babinski sign of clinical neurology. This sign is generally held to be pathognomonic of an organic lesion of the pyramidal tract. However, it has also been found to occur under conditions not associated with disease of the corticospinal tract, such as deep sleep, strychnine poisoning, tetanus, periods following epileptic seizures, hypoglycemic shock, coma, and several neurologic and systemic diseases. It can also be produced by the action of sodium pentobarbital and scopolamine, and has been noted after strenuous physical exertion, and in regressed schizophrenics (Gidro-Frank and Bowersbuch, 1948). Dorsiflexion in response to plantar stimulation is normally found during the first months of life and changes to the adult response of plantar flexion toward the end of the first year.

With these facts in mind, the startling nature of the experiments of Gidro-Frank and Bowersbuch can be appreciated. These authors were able to achieve the recovery of the Babinski sign during hypnotic age-regression in three adult subjects. The subjects (who were unaware of the nature of the experiment) were regressed to an age below six months by means of suggestions concerning their ages alone. Only nonspecific chronological suggestions were given. The authors state that: *"Unlike other physiologic changes brought about in hypnosis these were not elicited by direct suggestion nor were they produced by the hypnotic state itself.* A month-by-month study of the regression showed the alter-

ation of the response from plantar flexion to dorsiflexion to take place at the regressed age of five or six months. Reversal of the response to its adult form occurred at the same age in progression." Moreover, the change in plantar response was found to be accompanied by changes in peripheral chronaxie. During control experiments in the waking state the response was invariably plantar flexion. Voluntary efforts on the part of the subjects to produce dorsiflexion on plantar stimulation were completely unsuccessful.

Alterations in the visual fields during hypnotic age-regression are reported by Ford and Yeager (1948). These authors studied a patient who had a colloid cyst removed from the floor of the third ventricle in January 1943. Prior to this operation the patient exhibited a right homonymous hemianopsia. Following the operation his vision gradually returned to normal. When the individual was regressed hypnotically in 1947 to a period shortly before the operation, a right homonymous hemianopsia could be demonstrated.

Kupper (1945) has reported the appearance of a pre-convulsive normal electroencephalogram in a patient (who at the time of treatment suffered from convulsive seizures and possessed an abnormal EEG) during hypnotic age-regression to an age that antedated the onset of his epilepsy.*

The studies just cited show that measurable neurophysiologic changes can be produced by means of hypnotic age-regression unaccompanied by direct suggestion. That such effects are obtainable in normals as well as in diseased individuals is demonstrated by the work of Gidro-Frank and Bowersbuch who produced grossly observable reflex changes that could be reproduced at will.** These authors suggest that hypnotic regression to infantile levels amounts to "a functional ablation of certain cortical fields." How such hypothetical changes in cortical function are set in motion by the hypnotic suggestion: "You are five months old," is at present beyond our ability to explain. Nevertheless, the results of Gidro-Frank and Bowersbuch clearly indicate that simple chronologic age-regression under hypnosis is capable of producing profound neurophysiologic changes which result in the appearance of a

*This case is discussed in detail in the section of this paper dealing with The Electroencephalogram in Hypnosis.

**The photographs in the original paper should be consulted.

"pathological" (Babinski) reflex in normal adults. This is the best single piece of evidence available at present to support the thesis that hypnotic suggestion properly administered to suitable subjects can bring about psychobiologic changes in the total organism which are impossible of attainment in the waking state.

Conclusion

The literature which has been reviewed in this paper shows hypnosis to be a state identical with the normal waking condition according to all the physiological criteria which have been investigated. It is also clearly established that hypnotic suggestion is capable of bringing about physiological changes which differ significantly from those produced by means of suggestion in the waking state. There is good reason to believe that these changes differ quantitatively and qualitatively from those which can be obtained voluntarily. It is perhaps best to admit that we know nothing concerning the basic mechanisms involved in the process of hypnosis, and to restrict ourselves to the observation that hypnosis provides a remarkable opportunity for the study of psychosomatic interrelationships in the laboratory. Much valuable work has been accomplished in the past in the study of hypnosis from a physiological viewpoint and in applying the hypnotic technic to the study of the influence of emotions on bodily functions; yet it may be confidently predicted that the future will bring many more remarkable discoveries in a field which science has only just begun to explore.

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A complete bibliography concerning the physiology of hypnosis is not available at present. Adequate bibliographies covering the general subject of hypnosis are those of Hull (1933), Young (1926a, 1931, 1941), Jenness (1944) and Wolberg (1948). The titles cited here were selected from these sources and also from *Psychological Abstracts* and the *Quarterly Cumulative Index Medicus*, both of which were reviewed from 1934 to 1947, inclusive. In addition, practically all the references relating to the physiological aspects of hypnosis to be found in Dunbar's (1935) bibliography of the literature on psychosomatic interrelationships have been included.

This bibliography, therefore, while by no means complete, may fairly be said to contain all the work of importance published on the physiology of hypnosis during the last 25 years.*

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AFFECTIVITY, INHIBITION, INTROVERSION---CATATONIC STUPOR

BY POMPEO MILICI, M. D.

The catatonic dementia præcox, stupor reaction is the reaction of a fairly distinct type of abnormal constitutional personality make-up to an overwhelming psychic stress.

Under the direct influence of the affect, the person becomes pathologically inhibited and introverted. His interests consequently are withdrawn from the realities about him—with resultant disturbance of orderly thinking, and emotional, intellectual and physical inactivity with relation to the external environment.

As the inhibitory introversive influence of the affect deepens, the apathy toward external realities, the thinking disorder and the inactivity increase, and ultimately there is complete apathy, mental vacuity and inactivity. The course in this direction, however, is not always uniformly progressive and may be interrupted by manifestations of depression or elation, apprehension, suspicion, hostility, grandiosity or silliness and by fluctuations in the related fields of thinking and behavior.

With increasing inhibition and introversion of thinking, the person becomes absent-minded, abstracted; attention and comprehension are impaired; memory becomes vague and faulty; orientation is disturbed; bewilderment ensues.

For a time the person is aware of the thinking disorder. ("My thinking doesn't function like it used to. My thoughts are always wandering and I can't get them together. My mind seems to have lost its reasoning powers. I can't think clearly or correctly. I find it hard to make sense. I am getting dumber and dumber. My consciousness is introverted. My thinking is sleeping. I am dreaming wide awake.") He complains that something is wrong with his head (headaches and dizziness, the head feels "heavy" or "vacant," "distant," part or all of it is "tired, "numb," "blank," "missing"). The patient complains of strange thoughts troubling him, of fears of losing his mind, but as the inhibition further deepens—with increasing introversion and relinquishing of reality and in accordance with the affective tone—delusional ideas of a depressive type, ideas of reference and of persecution, of influence and control, with somatic and erotic coloring, replace insight.

A sense of guilt is often present, a remorseful haunting by the past, a feeling of great wrong committed, a fear of impending calamity for which the patient may consider himself responsible.

Hostile significance is seen everywhere. Environmental phenomena are misinterpreted and are referred to self. There is a feeling of being watched and followed, of being talked about and laughed at in an unjustified, ridiculing, accusatory way. There are ideas that people concentrate on the patient with witchcraft, hypnotism and telepathy, with electricity and radio; they threaten and experiment, put curses on him, control and confuse his thoughts and activities, break into his home where the contents are tampered with, and apparatus installed with plotting to kill.

The depressive affect, the inhibitory introversive influence, with withdrawal from reality and subjective confusion, lead to feelings of personal unreality. The patient speaks of a mist over him, feels as if he is in a fog, in a daze, in a trance, in a dream.

There is increasing difficulty, too, in grasping the facts of the environment. There are frequent references to the eyes, with complaints that vision is not clear, that it becomes dim and blurred. Distances seem distorted, objects appear to change in color, size and contour, people change weirdly, everything seems "different, changed and mixed up," strange and unnatural. The experiences then impress the victim as a stage play rather than as real life; everything is like a dream, it is a dream, it is a strange, new world, everyone looks alike, other persons are confused with dead and living relatives and friends, with doctors and with God.

The affectivity, inhibition and introversion are responsible for the considerable preoccupation with death, expressed at the various levels of regression. It may be expressed in a desire to die. ("I wish I were with my dead father. I would like to go home to Heaven. It is so beautiful to die. I am trying my best to die. I want a funeral. I wish to go to the grave.") Or it may appear as a delusion of dying. ("Life is draining out of me. I am sinking, my body is getting paralyzed, stiff, like a corpse.") The delusion may be of being actually dead. ("I am dead, in a coffin, under ground. They buried me. This is a cemetery. This is Heaven.") It may be projected as a fear of dying or of being killed, or of others dying, dead or to be killed. There may be

more general ideas of destruction and death, talk of fires and smoke, of shooting and war, of the end of the world.

At the higher levels, there may be considerable emotional display with active suicidal efforts and entreaties to be helped to death; but as the inhibitory introversive influences deepen the regression, the reaction becomes increasingly death-like.

The affectivity, inhibition and introversion responsible for the delusional structure are similarly responsible for the hallucinations, which are often stereotyped. Noises are heard, inanimate objects and people talk, there are all sorts of disparaging accusations. Voices ask questions, repeat thoughts, command behavior. There are conversations with the church, with the supernatural and with dead relatives and others whose spirits send messages, comment on doings, call the patient to Heaven. Voices promise to fulfill the desire for death, advise that the patient is dying, that he is dead, insist upon and threaten torture and death, discuss catastrophic and widespread killing. Lights and shadows appear; and there are visions of religious significance, of the supernatural, of dead relatives and others dead, beckoning, coming for him; visions of general destruction, torture and mutilation of population. There may be associated olfactory hallucinations.

The facial expression, which at the start is mobile, with tearful depression, anxiety and distress, becomes one of absorbed bewilderment, of fixed dejection and gradually, as the inhibition and introversion increase, loses its naturalness, becomes dull, stolid, dream-like, staring vacantly with diminishing blinking until it is immobile, mask-like, death-like.

The spontaneous stream of talk and the answers to questions are increasingly inhibited, retarded, diminished. Obstructions cause blockings, productions become incoherent, contradictory, fragmentary with scattered utterances, symbolism and stereotypy. The voice is lower, weaker, increasingly slow, monotonous, a dreamy mumbling, a barely audible whisper. Finally the attempts to answer yield only echolalia, a nod of the head, feeble, silent lip movements, after which there is complete mutism.

Attitudes and postures become awkward, constrained, statuesque, cataleptic. Movement becomes increasingly retarded, somnambulistic, automaton-like, and finally ceases.

The importance of inhibition-introversion in the symptomatology of the stupor reaction is clearly indicated by the varying levels

of emotional, thinking, and behavior disturbance, with fluctuation in the intensity of the inhibiting-introverting pressure. The patients themselves, during the freer intervals, often refer to the variations in the level of consciousness. "It comes and it goes. Sometimes I am myself, sometimes not. My mind is first on one way, then on another. One gets straight and the other gets dizzy. It is like two worlds, from one to the other, and I can't straighten things out in my head. Things change from one moment to the next. I think I am to be killed, then I forget about it. I feel myself dying and coming back to life. I think I am in Heaven, again not. Sometimes I lose my speech. Sometimes I lose my feelings. If I stop short and think, if I catch hold of myself I am all right for a little while. I work myself out of it, I wake up and everything clears up to me, things look suddenly natural again."

The patients' interests seem to be pathologically forced, and are attracted inwardly; and there is marked tendency therefore for spontaneous pathological introversion with its attendant abnormalities. The process can be stimulated, however, during periods of alertness by an observer's alluding to personal problems, whereupon the reaction of withdrawal is initiated and, as the patient sinks into introversion, the emotional behavior loses naturalness and progresses toward apathy. Relative clearness of thinking is replaced by preoccupation with dereistic associations with resultant disturbance of intellectual functions; relatively free natural activity gives way to negativism and to increasing inactivity.

Externalization of attention, on the other hand—either forced or stimulated by situations which attract the patient's interest, or require his attention—rouses the patient from his stuporous state whereupon the appearance, the behavior, the intellectual and emotional functions may become natural and normal and remain so unless there is return to a mood which makes for withdrawal into a catatonic adaptation, or to an affective pressure which so inhibits and introverts as to force the reaction.

Constitutional predisposition, overwhelming stress, inhibition-introversion of thinking, feeling and behavior, the death theme, these make up the formula of the stupor reaction.

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NUMERALS AND THE SEXUALITY OF SCIENTIFIC INVESTIGATION

BY WYMAN GUIN

A numeral is a graphic symbol representing to the human minds which use it, a number. The symbol is not the number, as "VIII" and a great many other symbols represent 2 X 4, as well as does "8." A system of numerals may be studied as a set of graphic symbols without regard to its function as numbers.

It is the purpose of this paper to discuss an apparent symbolic design in the Christian modification of Hindu-Arabic numerals and to suggest how this may be related to the psychosexual history of West Europe.

Observation

The "Christianized" Hindu-Arabic numerals do not have the obvious appearance of "counters" (|—|-|—|-|-|—|-|-|-|, etc.) as had been the case in Egyptian, Babylonian and Roman systems. Each symbol is a character as if it has a graphic significance apart from counting. An apparent symbolic design may be obtained from this system of numerals in the following manner:

(a) The symbols for unity and zero are set aside as polar symbols. (b) Between these polar symbols the numerals remaining are arranged in their sequence as numbers. (c) The eight centrally-arranged numerals are simplified graphically to combinations of unity and zero or its ares. (Figure 1.)

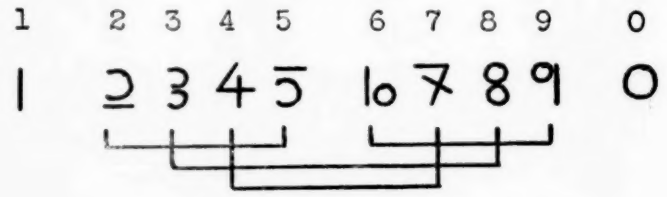

Figure 1.

When the numerals are thus arranged and conventionalized, pairs having obvious graphic relationships are disclosed. The symbol for two is rotated once in three dimensions to derive that for five. The symbol for six is rotated once in two dimensions to obtain that for nine. Graphically, three is half of eight. Seven,

written with a line across it, as is common in Europe, is a mirror image of four or it may be rotated once in three dimensions to obtain four.

These graphic relationships compose a formal design. They are always relationships between an even and an odd number. All half zeros are on the left. The symbols which are combinations of "1" and "0" or its arcs bound groups of four symbols. The symbols which create relationships between these two groups are derived graphically from only one or the other of the two polar symbols.

History of the Design

The symbol for zero developed in Buddhist India where it was represented variously as a dot, circle or cross. It passed to Islam, whence it had been preceded by Hindu numerals, sometime in the ninth Christian century.[1] It spread slowly through the Moslem world. The numerals were modified in several respects, and the zero was indicated as a superscript dot or circle. Probably from Islam, the Christian world adopted the decimal system with zero during the twelfth and thirteenth centuries apparently from the ghobār, or West Arabian type of numerals.[1]

Published examples[1] of Hindu-Arabic numerals as they appeared in Europe in the twelfth century cannot reasonably be modified to give the design in Figure 1. Systems of numerals employed in Europe prior to the twelfth century, such as the Boethian Apices, are removed from any tendency in this direction.[2] The systems of numerals, with a few exceptions, used from 1200 to 1600 show, in fact, various tendencies away from such a design. Hill,[2] however, gives an example from late in the thirteenth century from which the design may be obtained in that the five is written "  " the four as "  " and the seven as "  " and when placed in Figure 1, these symbols appear to be graphically associable. The first set of numerals which Hill publishes and which are exactly like our current numerals were used by Joanne Geddaeo Scoto in a book written for James VI of Scotland (also James I of England). It is thought from the similarities in style and execution that this woman taught his son Charles I of England and his daughter Elizabeth of Bohemia.

The fact is astonishing that the charlatans, magicians and metaphysicians of Europe did not use the numerical design in Figure 1

for powerful systems of pseudologic. This fact would require explanation if the design is an accident or artifact because it is so easily obtained and provides such an enticing abracadabra.

In the experience of the author occasional distraction by the obvious graphic relationships between the symbols for two and five and between those for six and nine continued for years without observation of the design. The design appeared abruptly when the symbols for unity and zero were isolated as polarities.

There appears to be considerable psychological resistance to the act of isolating the symbols for unity and zero so that the design may appear. The genital character of these symbols is evident before the design is recognizable. That is to say, supposing the design to be an artifact, it cannot be constructed without placing the symbols for unity and zero so that they suggest respectively the penis and vagina. It is necessary beyond that point to conventionalize the other symbols in terms of these two before the design appears.*

Not less interesting than the failure of charlatans to invent such an easy artifact is the general failure on the part of educated men to accord it conscious recognition.

Discussion

The conscious motivations of members of the primitive church were toward a state of "chastity." The conscious motivations of post-feudal Europeans were toward "sexual stricture." To understand the psychosexual climate of the centuries in which the design in Figure 1 appeared, the difference in these two "desired states" must be appreciated.

In a community motivated toward "sexual stricture" it is pleasure specifically which is abhorred. For example, children caught masturbating are frightened and/or punished physically. Sexual activity of all sorts is considered base, subhuman, dirty. The stricture is not organized. Eventually it extends amorphously over all pleasure and the situation of the individual is self-flagellatory. Sexual stricture is in sharp contrast to the systems of sexual

*The sexual implications of the numerals are obvious in the expression, "69," which refers to simultaneous, mutual oral-genitalism—sometimes heterosexual or female homosexual, but commonly male homosexual in character. In World War I, one of the finest of the French regiments—the Alpine Chausseurs—was the 69th; the taunt, "*Soixante-neuf*," from fellow-soldiers never failed to provoke a brawl.

taboo to be found in primitively organized societies. Taboo simply defines the available sexual objects, the sexual time, and possibly the manners of intercourse. In societies employing a system of taboo it is common for adults, not only to disregard childhood maturbation, but also to teach the little ones how to perform this operation for themselves.

On the other hand, sexual stricture is a state in equally sharp contrast to the actual as well as the desired state of "chastity" in the primitive Christian church. Havelock Ellis[3] has carefully defined this state of holy chastity. It was genuinely sought for its pleasures, not its pain. The Pauline ban on sexuality, the austerities practised by converts trying to forget the easy carnalities of Rome, died with a few early anchorites. The church itself turned to the pleasures of holy chastity. It is the very function of a sacred thing that it be (1) of great value, and (2) sparingly used. To these people sexuality was sacred and was saved as a gift to the God, Madonna or Son. Holy chastity was quite voluntary. Periods of pleasurably bearable temptation could be punctuated with transgression, since the early church recognized human frailty. Essentially, what was achieved was an atmosphere of intense sensuality seen today only among adolescents. What is pertinent to our present concern is that there was in these early centuries *no ban on knowledge of sex.* Even when the early enthusiasm for holy chastity had disappeared there was no compunction to sexual ignorance. The catalogues of offenses (penitentials) which appeared in the seventh century were details of sexual habits.[3] Certainly as late as the twelfth century, there would have been little compunction to overlook the genital implications of the Arabic symbols for unity and zero. Stricture on sexual knowledge was a later concomitant of the thirteenth century girdle-of-chastity and of the barbaric bride-purchase. As Frazer[4] has shown in the case of sacred animals, a thing once held sacred is held vile when the meaning of the sacredness has been forgotten. By the sixteenth century in Europe, the compulsion to ignore, to repress and suppress awareness of sex was quite general. The cause of the Protestants was assisted in no small measure because those who took their sexuality lightly certainly suffered most severely from the great syphilis plague of the centuries of the Reformation.

It is difficult to understand how the charlatan could have overlooked the opportunity to impress the gullible with the design in

Figure 1. On the other hand, it is not difficult to understand that the scientist and mathematician remained unaware of this naïve symbolism. His unconscious use of these symbols has an interesting bearing on the compunction to seek knowledge and to employ the objective approach when these activities are viewed as an adaptation to blocked infantile sexual investigation.

Knowledge gained in the passive sense characteristic of the centuries of sexual stricture in which the "university" developed—that is, listening to lectures and reading books—has a recognized relationship to disturbed sexuality. The situation is exemplified in a case history reported by Chadwick[5]: "Knowledge, to know, to find out, or rather to be told, to go on from one course of study to the next, without waiting to make use of them, to pass one examination after another, provided her with intense gratification, which during the course of her treatment showed itself as the direct outcome of being denied information by her mother and being told things that were manifestly untrue by both parents. She determined to find someone who would tell her all. She could not find out anything for herself, by reasoning, deduction or reading."

It is germaine that James I for whom Scoto wrote the book containing the first clear example of our current numerals was, though uncreative in his literary efforts, pedantic and highly "educated," because of the ministrations of a rod-wielding teacher. He was in addition homosexually inclined and "behaved basely in regard to the execution of his mother." He wrote a violent treatise against witchcraft. Concomitant with the transition from Christendom to nationalist Europe there was a revival of magic and witchcraft as well as of science, these activities being resisted impartially by the church.

In France, Gille de Rais had sought to transmute base metal to gold. His methods involved unspeakable sexual perversions upon uncounted scores of dying children. But there is one startling feature of his activities which should not escape us. He sought a verifiable end. He did not repeat indefinitely ceremonies which failed to obtain that end. He altered and extended his "experiments" in pursuit of that end. This conduct is in sharp contrast to the behavior of the magician.

More "sanely" in the rest of society, exceptional children converted their blocked infantile sexual investigation into ordered investigation of "mother" nature. In one of his finest studies

Freud[6] deals with the motivation to scientific investigation as the rarely encountered third adaptation to blocked infantile sexual investigation. Not until after P. W. Bridgman's "operational thinking" is the conduct of scientific method demonstrably clear of the motivations Freud attributed to daVinci.[6]

Freud has remarked the manner in which daVinci employed numbers and exact but superficial calculations at points where they apparently blocked an expression of deep emotion. Thus Leonardo never entered in his diary mention of important expenditures; but the petty expenditures incurred for his loved pupils he entered with painful exactitude, listing the items and pennies. Leonardo refers to the death of his mother in such a distorted fashion that indeed we are not certain the Caterina mentioned is his mother. There is an abrupt entry: "Burial expenses following the death of Caterina . . ." There follows an itemized account of a lavish funeral including one item worded, "To 4 priests and 4 clerks . . . 20 florins." Freud subjects to analysis an interesting slip of the pen in Leonardo's entry concerning the death of his father, "On the 9th of July, 1504, Wednesday at 7 o'clock, died Ser Piero daVinci, notary at the palace of the Podesta, my father, at 7 o'clock. He was eighty years old, left ten sons and two daughters." Freud points out that we might expect in the place of the second barren reference to the time of day a statement of sentiment such as "my poor father." This will serve at any rate to illustrate the point that seeming objectivity is not always a matter of disinterest.

It was a custom at the time of the Renaissance to alter and select numerals according to the taste of the individual. It is conceivable that as sexual stricture increased, there was unconscious selection of forms which gave a pleasing design based on genital implications. In the hours of contemplation or the drudgery of commercial activities, suppressed desires were entertained. It is possible, too, that some affection-starved soul such as Joanne Geddaeo Scoto invented the modern forms without conscious admission of their implications. If so, it was a later soul who wrote the seven as "" thus completing the design.

Summary

1. A simple method is described for obtaining a formal design of graphic symbols from the current Hindu-Arabic numerals.

2. This design has genital implications to West Europeans.

3. The psychosexual climate of post-feudal Europe has been such that general unawareness of this formal design might be expected.

4. Some observations by Freud are recalled in the light of which this design is of special interest.

ACKNOWLEDGMENT

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FROM THE AUTOBIOGRAPHY OF A LIAR*

Toward the Clarification of the Problem of Psychopathic States

PART TWO

PART TWO: INTERPRETATIVE

I. Background and Family Interrelationship
II. Instinctive Emotional Life, Greed and Rages
III. Morality, Conscience, Guilt
IV. Lying
V. Differential Diagnosis
VI. Finale

It must be obvious to anyone who has read the foregoing survey that any satisfactory discussion of this case is all but impossible for two very cogent reasons: (1) There is insufficient anamnestic data by which to check the patient's narrative; (2) the value of the patient's narrative is much diminished because we are convinced that at least 50 per cent of it is false.

This man had absolutely no regard for the truth. His narrative was written piecemeal at the instigation of the physician who was studying his case, and its numerous contradictions and inconsistencies are partly due to the fact that from time to time he forgot what he had written before and had no more interest in the continuity of his story than he had in its truthfulness. At the same time, one cannot escape the impression that, on many occasions at least, he thoroughly enjoyed writing about himself and his advèntures; that he possessed a lively imagination, from the exercise of which he derived considerable pleasure, entirely unrestricted by any regard for fact. An attempt to sift the small measure of truth from the great mass of falsehood would be a nigh impossible task. All we can do is to consider those aspects of his narrative which give a fairly clear picture of his character and personality make-up; and, in the light of these, to speculate a bit on some of the probable circumstances which he has so obviously misrepresented.

*This is Part Two of a two-part paper. Part One was published in the April 1949 PSYCHIATRIC QUARTERLY.

I. *Background and Family Interrelationship*

The Father: According to the official record, a brother of the patient has stated that their father was jealous, very cruel and would whip the children for the slightest offense. This is certainly easy to believe. We know that the patient himself is "very cruel"; that he possesses an uncontrollable temper and is continually belligerent; that his dreams are filled with pictures of assault and that some of them contain scenes of sadistic fury; that the murder for which he is serving sentence was characterized by ruthless brutality. It was a predatory, mercenary crime, a human being killed for a few dollars. It is more than likely that he comes honestly by his violent disposition, and that it is to some extent a "hereditary" trait. The patient, in the official record, and in one place in his narrative, describes his father as a saloon-keeper. Elsewhere in the narrative, he is a carpenter (with a college education) and a contractor. The saloon-keeper designation is the more probable. Certainly, there is no reason to believe that the father possessed any unusual attainments. The patient's narrative describes him as a good parent up to a certain period, and as a very bad one thereafter. It is more likely that he was always a bad parent, and that the brother's statement (we do not know whether this is an older or a younger brother) is more or less applicable to his entire life.

The Mother: This same brother is also quoted as speaking of the patient as "being kind to their mother and always doing his part of the chores around the house." The patient himself claims to have loved his mother and to have been deeply grieved at her death; but he also stated that she died while he was in France during the war. It is almost certain that the patient was never in France. He does not say where his mother died, and the medical certificate states that she is an inmate of a mental hospital. On the basis of the patient's narrative, it is difficult to imagine him as being "kind" to any one. The brother's statement is the sort of thing a relative invariably says in an anamnesis, and is probably as conventional as the patient's own statement concerning his grief over his mother's death.

Attitude Toward Parents: At the same time, we are certainly justified in assuming the existence of a great deal of father antagonism, and it is possible that, in contrast, there was a certain degree of mother attachment, or at least of mother preference.

Speaking of his mother, the patient says: "When I lost her, I lost the only friend I had in the world." This also is primarily a conventional statement, and a rationalized excuse for his general attitude of hate. He continues: "A mother is a man's only friend—and if she had not died, I would not have been kicked and so badly used by the world." But his voluminous narrative contains not a single mention of his mother during all the years that he was hither, thither and yon, gambling, fighting, fornicating, cheating, robbing, and serving time in jails, reformatories and penitentiaries. She was certainly "out of sight, out of mind," insofar as his own account is concerned, from the time he left home. We can only conclude, therefore, that his attitude toward his parents was precisely what it was toward everyone else—a parasitic and predatory one; that his only interest in them was contingent on whatever they could do for him or what he could get out of them.

Siblings: His account of his siblings, as we have seen, is a fanciful hodge-podge of weak memory and strong imagination. We do not even know how many he had. The official record states that apparently he was one of five children; but his own narrative has increased this number to 11; and it is obvious that, if he left home at an early age, he could not have known most of the things which he relates about them. His attitude toward them must have been one of complete indifference, for we never hear anything about them in the balance of his narrative any more than we do about his mother.

The medical certificate states that one sister is also an inmate of a mental hospital. During one mental examination, the patient voluntarily stated that he had himself been confined to a mental hospital for a year, but there is nothing in his narrative which corresponds to this statement, which may or may not be true. He has variously given the date of his confinement as 1896 and 1906. On both occasions he said that he was confined "over a year," and, on the second, he said that "he was taken there on account of fits he used to have," fits which, from his description, sounded to the examiner like epileptic convulsions.

Nothing has emerged from his recital that points to the presence or absence of psychogenic factors on the basis of which we could explain the man's personality.

II. *Instinctive Emotional Life, Greed and Rages*

The chief emotions with Cooksey are those that go with the need to satisfy immediate needs and wants. And he is always in need and in want; he is pure instinct in action. With the sympathetic emotions totally lacking, those that he readily experiences are connected with feelings of hate and fear. But there is nothing deep or lasting about these; rather they are short in duration, lasting virtually no longer than the stimulus-situation lasts; but for all their brevity unusually strong, even violent in their expression.

His rages come closely to being "epileptic equivalents." The likelihood is that he had tantrums throughout his lifetime, whenever he met with any sort of frustration, and that these increased in scope and violence as he grew older. Thus this appears to be rather a case of an inherently defective and warped personality almost from the beginning—a truly "psychopathic" personality manifested by aggression, depredation, ruthless brutality, and complete disregard for all others. At the same time one notes the remarkable absence of virtually all that may be regarded as having a positive social value. The man never made the least sacrifice for any one.

Temperamental Imbalance: Cooksey has a violent temper, especially evident when some one hurts him or interferes with his actions. He brooks no opposition and will assault any one who happens to be in his way. Because an employer refused to pay him (and the employer may have been right at that), he stole the man's watch and wantonly destroyed his property. He is projective, carries grudges and is very revengeful. He is impulsive, loses his temper easily, fights on the least provocation. In and out of prison, he makes unprovoked assaults, the violence of which appears to be out of proportion to the situations. Outside he is arrested for assaulting a Negro and sent to the reformatory. A commonplace remark infuriates him and he will stab a fellow prisoner, disfigure a "stool pigeon" for life, then brag about it. To be sure, "stool pigeons" do not stand well in any prison community; but Cooksey did not assault the man he disfigured because he was provoked by betrayal of the group interest, but chiefly, it seems, to let out his aggressive hostility.

Sex Life: His sex life is characterized by a virtual lack of control or ability to defer pleasure. In the choice of mates or partners, there is no great preference. Every woman teems with pos-

sibilities; the nearest is the most beautiful. A woman to him is merely something or somebody to relieve tension. It is beyond him to love or be kind to any one. He cannot exchange emotions or effect binding attachments, for that means an ability and willingness to share himself with others. This, a person of his type, absolutely cannot do. While he frequently speaks of himself as "tender-hearted" and perhaps actually thinks of himself in this way, we shall be hard put to find any evidence of tender-heartedness in his narrative except in situations which are certainly the product of fantasy.

His excessive heterosexuality, equaling satiation, has already been noted but not once through his 40-odd years of life did Cooksey ever show any expression of love or affection for women, not even the ordinary regard of one human being for another. To him women were good for purely physical purposes only. Though he tries to give the impression of having been in some sort of affectionate relationship with women, his statements all sound hollow, for they are only verbal and are not backed, even verbally, by any overt acts. The narrative lacks any evidence of devotion, of ever having made the least sacrifice for any one—man, woman, or child.

On the other hand, we see nothing but greed and lust in his dealing with women. He has made a specialty of deceiving prostitutes and stealing their money. He not only admits being a pimp, but shows no concern about it and apparently does not appreciate the social stigma connected with it. If he is not satisfied with his wife, he just leaves her, then remarries, not bothering about such things as laws against bigamy. What did marriage mean to him? Only a means to get the woman he wanted if he couldn't get her in any other way. His desertion of a pregnant wife is a piece of behavior unusual even for an extreme neurotic but is entirely characteristic of Cooksey. He had relations with his father's second wife, showing complete disregard for the most ordinary conventions of decency.

His reputation for homosexuality was wide and was corroborated from many sources. One might suspect that prison confinement denying normal outlets, led to facultative acceptance of homosexuality. But we have also his statement that even when free

he indulged in homosexuality; and in another place he described homosexual relations as arousing passion such as he didn't find in heterosexuality. He is truly bisexual.

Social Attitudes: As already pointed out, Cooksey has no communal feelings, no group solidarity, no social interests whatever. He is entirely an isolate. The long history fails to disclose that he ever went out of his way for anyone, that he ever was attached to anyone by any sort of sentimental ties. He claims to have pleaded guilty on one occasion to save another fellow from being disgraced; this is most doubtful, because it is inconsistent with his other behavior. For on another occasion he recites a theft of jewelry which he blamed on somebody else who was then flogged for it. In all his interpersonal relations he was always on the taking end, not on the giving side. What is given him he takes as a matter of course, like an infant or animal does, without showing the least appreciation or expression of gratitude. In most instances, however, he does not wait to be given; he forcibly takes it, assaulting the environment if need be—and there is always that need—and extracting from it what he can.

He has no objective interests in the society of which he is technically a member. There is a total lack of responsibility. There is no goal or evident purpose in life; there is an absolute lack of ambition, but throughout only overwhelming egoism and vanity. In each recital of fights, he always came out the victor.

Antisocial Behavior: His narrative presents a progressive series of antisocial acts—predatory, sexual and against person, accompanied by repeated sentences to every type of institution-confinement. Throughout this all, one fails to note an ability and willingness to profit by experience, or to express any different attitude on expiration of a sentence. He is incurable and unteachable in the worst manner of the true psychopath, who is apparently "constitutionally" incapable of being other than he is; being unable to condition himself to cultural standards; or to have any other viewpoint than one of impulsive predatory aggression. In his presentation of the circumstances of the crime he willfully forgets the true facts because they violate his egoism; he manufactures the false situation more because it flatters his egoism, than because the truth embarrasses him social and ethically.

III. *Morality, Conscience, Guilt*

Moral Code and Guilt Reactions: For practical purposes, the reaction of guilt is nonexistent in this man's personality make-up. He has no moral code. Cooksey just can't do wrong or be wrong. Guilt and doing wrong mean no more than fear of being caught and receiving punishment. But there is an ever-readiness to projection; there is always somebody else who is at fault.

The man has no inkling of anything that has a semblance to human sentiment. He had just as soon rob a woman of her possessions after she trustingly yielded to him, as rob his fellow-soldiers. Where the neurotic criminal driven by some obscure emotion is likely to commit even such despicable crimes, he quite universally recognizes the wrongness of his act which is usually followed by feelings of remorse and at least attempted rationalization. But not only does Peter Cooksey not see anything morally wrong in his behavior; he even prides himself on his cleverness. So far as he is concerned, it is all right to get anything he can from whomever he can and in any way he can.

Glimmerings of Conscience; Fantasy Life: Only once, in connection with his long recital of homosexual activities, does he make any statement that betrays even the slightest sense of guilt. He speaks of having done "disgraceful things," but excuses himself on the ground of his youth. To the overwhelming social prejudice against homosexuality, he bows with this slight, and only half-hearted, concession; but upon every form of dishonesty and brutality, he turns an approving eye, so long as it is he himself who has been dishonest and brutal.

At the same time, as we follow his narrative, there emerges from the depths of his twisted nature some indication of a wish that he might have been different; some sort of a very feeble super-ego—but one not expressed in any action, however. This is never expressed consciously; it takes the form of fantasy and accounts for some of his lies. How else can we interpret his detailed description of his childhood home—a description which we have every reason to believe is completely false—where everything was so well ordered and where the conditions were so harmonious, the children so well protected from dangerous contacts with others, etc.? How else can we interpret his idyllic account of his courtship of Agnes (who is supposed to have been his first wife), with its recital of all the fine and generous things he did for her and

her little brothers and sisters? How else can we interpret his dreams about children and his elaborate account of the care and affection he bestowed on his little brother? That any of these things are rooted in reality, it is impossible to believe. But it also is difficult to believe that all of them have been willfully manufactured to produce an effect, although this was probably part of the motive behind them. They would appear rather to be the result of wishful thinking; a form of fantasy which feeds his egoism and tells him what a fine fellow he was. Then, when he gets tired of playing this fantasy game, he brings the story to an abrupt and inconsistent ending, such as that of the sudden disappearance of his first wife and their children; the equally sudden disappearance of his second wife, who wrote him that she could no longer live with him because their baby had died, etc., etc.

There is nowhere in his narrative any expression of an intention to be different; he probably did not possess the will to be different if he had wanted to be; and there is no indication that he ever really wanted to be, insofar as his conscious reactions are concerned; but there is nevertheless an indication of an unconscious dissatisfaction with himself which he soothes by telling these lies about himself, according to which he *was* different, or at least had periods during which he was different. Something within him craves the satisfaction that comes from doing fine and generous things, so he imagines that he *has* done them. If we were in possession of the true history of his relations with Agnes, Cecilia and Evelyn (the three women whom he claims to have married), we are sure that we would have three sordid and ugly stories that would be quite in keeping with his criminal career. We simply cannot imagine him as ever having loved any woman or as ever having been kind to any woman. He frequently speaks of himself as "tender-hearted," and perhaps he actually thinks of himself in this way, but we shall be hard put to it to find any evidence of tender-heartedness in his narrative except in such situations as we have just referred to, which are certainly the product of fantasy.

But even a "tender-hearted" fantasy argues for the existence of some potential element of good. We have the hospital record of his crying when it was certain that he thought he was unobserved, at the same time voicing incoherent statements about "who would be next" (in which connection it was stated that some of his actions were "distinctly expressions of psychosis"). His state-

ments about "who would be next" were assumed to fit into a persecutory pattern and to relate to others. On one occasion he was heard to say, "you will be next, you s. o. b." But it is also known that this sobriquet, s. o. b., was the one most commonly applied to him by others, even to his face. While it was supposed that these moods in which he had been observed were those of self-pity, it was also commonly supposed that his remarks were addressed to imaginary enemies. No consideration seems to have been given to the possibility that on these occasions he might have been addressing himself and to have been preoccupied with the fear of death.

IV. *Lying*

One may say that Cooksey's whole narrative is a tissue of lies but that would hardly cover the situation. To be sure, he makes many conflicting and contradictory statements but in our view they must be differentiated and, though consciously expressed, cannot be regarded merely as acts of willful omission or commission but rather as directed by unconscious motivations. Without outside sources of information about any of his contradictory or even impossible statements, we can only check these against internal evidences. At times, it seems that he simply lets his imagination run away with him, perhaps to please or impress the physician. At other times, it appears that he is actually somewhat confused.

Family Background: There has been, throughout, a marked tendency to embellish the family background by elaboration of hearsay or by flights of pure imagination. He makes his father a college graduate, which is highly doubtful in light of subsequent statements concerning the type of home his father had and the type of activities in which he engaged. His mother is pictured as a woman of many and high virtues, presumably because this is what the patient thought is socially expected of a mother. A good mother must have a good son. He describes a harmonious family life, which can hardly be the case because there is so much else which contradicts it. It is inconceivable that such a hard-boiled, ruthless, heartless criminal could have come from such a wonderful environment which should have had some influence on his development, but the influence of which is nowhere evident. His description of a beautifully-furnished home is an imaginative wish-

fulfilling picture that does not fit in with the background, which was more than likely one of poverty and squalor, a fact which he was trying to conceal.

In the light of other episodes related, the alleged strict supervision of him as a child in the early home environment does not sound at all plausible. It is more a statement of what might have been than a true statement of what actually was. He is trying to create a good impression.

In the account of his early school life, he paints a picture of himself as a model little gentleman and something of a hero. It is difficult to believe that out of such a background there could come such a hardened criminal personality.

Education: It is doubtful whether he ever progressed beyond the sixth grade, (this being his statement) if that far. But he has spoken on one occasion of having finished high school at the age of 20 and even of preparing for college. He writes, "I was borned," instead of, "I was born," which one would hardly expect of a high school graduate. We, therefore, confidently accept the first statement. Furthermore, there is no account of any education to bridge the gap between the sixth grade and high school.

Spasms: In speaking of illnesses he talked at great length about spasms which he developed following measles. This, of course, is not unlikely, although it seems that he has greatly exaggerated their severity and has pressed these into service to the point of describing a brain hemorrhage resulting from one such spasm. Whenever he wished to get out of a difficult situation, such as being excused from hard labor in prison, or trying to get to St. Elizabeths Hospital, he promptly called these spasms into service. This is fairly typical hysterical reaction.

Early Delinquencies: He ran away from home at an early age. Good children, it is believed, do not run away from good homes though bad children do; while good children stay, even in bad homes. With as many children in the home as he describes; with little supervision; and the boy bent on having things the way he wanted them, it is likely that he ran away because of poor discipline, perhaps because of his inability to accept any discipline.

Criminality: The frankness with which Cooksey describes criminal activities suggests lack of insight and a complete lack of appreciation on his part of their social meaning. He readily admitted his numerous crimes; indeed he sees nothing wrong in commit-

ting a crime. A great deal of resistance, however, was encountered in getting him to tell of his sex life. While heterosexual activities were reported in detail, he originally denied any homosexual activities, a denial which would be hard to believe because of his reformatory environment, if for no other reason. Later he admitted these, although minimizing them, thus showing the effect of social repression. He records that he was once arrested for shooting a mule, an act of which he says he was not guilty as it was done by his companion, but to which he nevertheless claims to have pleaded guilty in order to save the other fellow from being disgraced. This is thoroughly inconsistent with what we know of his character. He is more likely to blame anything on someone else.

Sex Life: Cooksey's account of his sex life, like so much else in his narrative, is tempered and colored by his narcissism, and by the practical consideration of what will do him the most good at the moment. He will deny an event or a series of events if, in his opinion, an admission of these is likely to reflect badly on him. To the same extent, he is likely to exaggerate or embellish his behavior if he thinks that this might lead others to think better of him. Oddly enough, he never actually does anything that would make others think well of him. If he is frank in his statements of his criminal behavior, it is because: (a) He thinks there is nothing wrong in such behavior; (b) he thinks that it impresses others with his cleverness. For the same reasons, one may well believe his recital of his rather extensive sex activities, even if he has slightly embellished it here and there or omitted some unfavorable aspect of it. The chief embellishment is by way of injecting tender emotional overtones into his relations with women. These are probably absurd lies, for we know that he is absolutely incapable of anything resembling a tender emotion. But he knows intellectually, even if he cannot experience tenderness emotionally, that this appeals to people and is what may raise him in others' estimations.

It is very doubtful whether we would be justified in calling these exaggerations expressions of fantasy life, for we question whether he is capable of fantasy-weaving. As we see it, they are more in the nature of immediate responses to the present situation; he is too prosaic and and commonplace a person for fantasy; there is nothing in him of the neurotic's rich fantasy-indulgence. Omis-

sions consist in his pretending to have been all pure innocence in sex matters during his childhood and adolescence, pretentions which are completely shattered by his subsequent recital of experiences with colored girls at the age of 12. But this is entirely in line with his idea of what he should claim in order to make a good impression.

Marriages: The history of his marriages is remarkable for its many and glaring inconsistencies. It is even questionable whether these marriages ever took place, at least in the manner described. He has given us two different versions of his first marriage. Both sound far more like elaborate fantasies than records of fact. He claims that with wife No. 1 he had two children —now two girls, and, on other occasions, two boys—and that during that period he worked honestly and then she suddenly disappeared—why, no one knows. A happily-married woman with two children does not disappear from home without any warning and for no known reason. There is, therefore, definitely something here which he has omitted. If his wife did run away, the great probability is that he made life so miserable for her that she was forced to leave him.

Suicidal Attempt: It is not unusual for a neurotic to get himself involved in a maze of difficulties from which he feels he can find escape only by way of suicide. The attempt may be in all earnestness, whether it succeeds or not, or it may be gestural, in the view or the near view of others, as in the case of some hysterics. There is no record whatever from the prison that Cooksey ever made the least suicidal attempt or even a suicidal gesture. We only have his statement of a presumed attempt. But it is characteristic, even typical, of the true psychopath to make statements which cannot be substantiated or verified. For this reason we are inclined to discount entirely his claim of a suicidal attempt. True psychopaths do not commit suicide; unlike neurotics, they do not even attempt it. In the words of another patient of mine, a psychopath: "I wouldn't hurt the skin of my little finger; I wouldn't hurt myself for anything."

The Murder: His version of the murder is the very opposite of the official record. It is entirely doubtful that the man is so mentally confused that he cannot distinguish between fact and fiction. Two possibilities are involved here: either a genuine hysterical amnesia or willful conscious falsification. Hysterical amne-

sia usually develops in an acute emotional setting. But the murder which he actually committed involved no emotional situation such as might be found in cases of amnesia, but was exclusively predatory. Any idea of amnesia, therefore, would seem to be ruled out. It appears most probable that the patient has deliberately substituted the false circumstances because they lend themselves readily to his manufactured "delusions." Here is more a case of stubborn persistence in an absurd falsification of facts. This might well argue for a gross defect of judgment, for certainly the patient knew that the established facts must be a matter of court record; but it is quite possible that he has told the story over and over to himself until he is nearly convinced of its truth; and that it has completely taken the place in his mind of the events which actually led to his conviction and imprisonment, but at the subconscious rather than the unconscious level; by suppression rather than repression. The patient's account is the more questionable because it is next to impossible to imagine a death sentence under such circumstances as he has described, even allowing for the possible influence of racial feeling and prejudiced jury. There is, therefore, every reason to dismiss the patient's account altogether.

Analysis: If all lies are not alike either in origin and development, structure and function, and must be differential, it becomes then necessary to analyze more specifically Cooksey's particular type of lying. We may well dismiss the possibility of an organic condition, such as a Korsakoff's psychosis, for aside from his stories which are wholly unlike confabulations, he has not shown a single feature of an organic psychosis. Nor, as discussed elsewhere, is there any evidence that he suffers from a functional psychosis and its associated memory disturbances. While the murder could have provided an opportunity for amnesia, the fact that it was a brutally cold-blooded, mercenary crime with no emotional involvements, would definitely exclude such amnesia. There remain two likely possibilities: pseudologia phantasica and pathological lying. While the prisoner reports for us a finer background than we could possibly concede him, it is not at all out of the limits of general possibilities; there is certainly no castle-building, no royal parentage, no search for glamor such as we find in the pseudologue. Nor do we find in him neurotic symptoms that are characteristically found in pseudologues. By exclusion and other considerations, the case is clearly one of pathological lying.

Cooksey's lying is only slightly compensatory, is chiefly opportunistic and defensive, and much of it is at a conscious and near-conscious level. Rather than being expressive of disturbed and unsatisfied emotions, his lying shows either a grossly defective intelligence, or a defective use of a normal intelligence because of particular emotional motivations. No man with a modicum of sense could produce such glaring inconsistencies in narration, or make at one time statements which were so completely the opposite of those he had made at another time. While his longer and more elaborate lies at first suggest fantasy-building, it is, of course, apparent that he is simply not the type of individual from whom fantasy can be expected. There is nothing of the hysteric or neurotic about him and a closer examination reveals that these long stories lack any element of originality, but are represented by extensive, if not exclusive, borrowing from whatever he has seen or heard or read. Widely differing as they may and do, their purpose is invariably the same, to make him appear to be a different and better type of man than he really is; and, while their motive is always strictly utilitarian—according to his defective judgment, with its utter disregard of consistency—there does appear also to be a certain wish-fulfilling mechanism involved. Reading his persistent attempts to make himself appear good and kind, generous and self-sacrificing—when we are almost persuaded that he never had an unselfish impulse in his whole life—we glimpse nevertheless a certain underlying realization that he is not what he should be, and a corresponding wish that he might have been different; that he might have conformed as a matter of fact to some of the socially acceptable patterns which he has seen and heard and read about. This wish is father to the thought; and when he proceeds to write about himself, in order to ingratiate himself with the physician, the wish becomes for the time being a fact. As he would have liked to be, or as he thinks others would like him to have been, so he was; and we thus have these long fabrications which serve the two-fold purpose of patting himself on the back and impressing his readers. But this is not the fantasy-formation of the neurotic, who is more or less conscious that he is daydreaming or playing an imaginative game, and who would never seriously contend that his fantastic flights of fancy were predicated on fact. Cooksey's stories represent a conscious attempt to deceive, coupled with a mental incapacity to appreciate

the absurdity of his attempted deception. This mental incapacity, however, is not in any way due to lack of intelligence. It is caused by emotion which detours, or re-directs, the intelligence into wrong channels. His stories also betray a complete lack of anything resembling mental continuity. One story does for today, another for tomorrow, and a third for the day after; and there is no thought of making them agree or of weaving them into a connected whole. Each serves what he considers its immediate purpose, and is then forgotten. To this extent, his pathological lying is closely tied up with a certain degree of mental deficiency. It is not, however, the deficiency of the mental defective, but rather that found in the classical type of psychopathy—wherein the primary need, "to have and to hold," assumes a superior importance and priority over more desirable social behavior, which is to defer pleasure for the sake of later socially-approved advantages.*

V. *Differential Diagnosis*

Neurosis? Our subject presents so many contradictory personality traits that it becomes important to correlate and classify these. His narrative is characterized by the absence of a number of personality traits universally found in neuroses. Chief among the latter are emotional lability, extreme sensitiveness, and impressionability, tender emotional attachments, emotional ambivalence, and, on the mental side, high suggestibility, conscience and guilt feelings, the presence of psychological mechanisms such as repressions. No such reactions are observed in our patient. His instinctive life in general and sex life, in particular, are not merely strong, but unbridled, showing high impulsiveness and lack of control and inhibitions.

Deteriorating Psychosis? If it seems doubtful that, as one physician stated, "the total personality" had become involved in behavior reactions consequent upon deterioration, it does seem highly probable, however, that the harsh treatment to which he had been subjected during his life as a prisoner had resulted in a certain lowering of resistance and a general reduction of stamina. This would not be surprising, even when allowance is made for considerable exaggeration in his accounts of punishment, for his narrative is a strong indictment of prison administration, and we

*For a more definite study and differentiation between psychopathy and mental deficiency, see the author's: Moral agenesis. PSYCHIAT. QUART., 21:3, 361, July 1947.

know only too well from many other cases that his accounts of prison brutality are substantially true. This applies particularly to that section of the country from which he came.

Psychopathy? Deterioration of personality is certainly not indicated by his writing—unless one wants to say that his never-ending lies are an evidence of deteriorated personality. It would seem rather to be a case of a man who possessed a defective and warped personality almost from the beginning—a truly "psychopathic" personality manifested by aggression, depredation, ruthless brutality, and complete disregard for all others. His narrative presents a progressive series of antisocial acts—theft, the destruction of property, cheating, robbery, pimping, blackmail and murder, accompanied by repeated sentences to reformatories, chain gangs, convict camps, jails and penitentiaries; and, at no time and in no place, is there the slightest intimation that he learned anything from any of his unhappy experiences or manifested any different disposition after serving a sentence than he had manifested before. He demonstrates, all the way through, the incurable and unteachable nature of the true psychopath, who is apparently constitutionally incapable of being other than he is, of having any other viewpoint than one of blind, predatory aggression.

At no place in his narrative does he ever take himself to task, concede error or short-sightedness, or give expression to any feeling of guilt or remorse. It is doubtful if at any time in his life he ever felt guilty about anything. His narrative is permeated with the spirit of exhaustless egoism. He reminds us of Little Jack Horner, who "stuck in his thumb and pulled out a plum and said, 'What a good boy am I!' " It would seem as though he were constitutionally incapable of admitting guilt or even appreciating what it meant.

As we have already seen, he either cannot or will not bring himself to admit the facts of the murder for which he is serving a life sentence, but persists, instead, in relating a story in which he is something of a hero as well as a victim of persecution. He didn't brutally and ruthlessly kill a taxi-driver with a hammer in order to rob him. No indeed! He avenged an insult, and—with a single blow of his clenched fist—killed a Hawaiian, who had said that all white men were yellow. It is absurd to argue that he does not know the difference between these stories. He willfully forgets

the facts because they affront his egoism; he manufactures the false situation because it flatters his egoism. When he speaks about stealing a roll of bills from a man's trousers while the latter is asleep on a boat, or of stealing a woman's handbag after he has had intercourse with her, or of holding up a car full of soldiers, we get the definite impression that he thinks he is really pretty clever and is quite proud of himself. There is not the slightest suggestion that he regards what he has done as morally wrong. There is nothing morally wrong, insofar as he is concerned, about getting anything he can in any way he can.

Prison Psychosis? The outstanding question in this case, of course, is whether the patient was suffering from a psychosis. The weight of evidence appears to be in favor of a negative conclusion. That he was a malingerer has been established beyond any doubt. The marked contrast in his behavior under observation by nurses and attendants, and that shown in the presence of physicians is sufficient indication that he was "faking." Moreover, he has admitted this to a number of his associates, all of whom, as well as all nurses and attendants, are agreed that he was in full possession of his mental faculties and that his claims of delusions, hallucinations, etc., were manufactured for his own purpose, which was to gain admittance to a mental hospital from which, he thought, there might be some chance of escape.

In a rather lengthy case note, one physician has given consideration to the possible mental involvement as follows:

"The family history is of significance, for if there is a constitutional weakness in this patient, we would expect an hereditary taint. We learn that the mother and one sister are inmates of an insane asylum.

"Constitutional moral imbecility, or the lack of appreciation for moral standards, is frequently associated clinically with evidence of organic brain disease. The history of 'spasms' accompanied by loss of consciousness at the age of eight or nine years, followed at the age of 12 by violent temper tantrums and unmanageable assaultive behavior toward other children, suggests an epileptic syndrome of the psychomotor type. The appearance of sudden rage reactions in such an individual may be considered epileptic equivalents.

"Associated with psychomotor epilepsy there is frequently some degree of mental deficiency. The school record is indefinite; the

brother states that he completed only two grades of school while the patient states he completed eight or nine grades at the age of 17. His letters are consistent with an eighth grade education, but other features of his behavior, and his ability to control the situation in which he is placed, indicate an innate general intelligence of at least low average normal level. Psychometric tests would be helpful in establishing this level.

"The problem of differentiating psychosis from malingering is frequently encountered in institutions for the criminally insane. With this patient the problem appears quite simple. According to those who observed the patient closely both in the penitentiary and at this hospital, he definitely 'played up to' the authorities, consciously exaggerated and manufactured his symptoms, for the obvious motive that life was much more pleasant here than in jail.

"On the other hand, the behavior reactions of this man had deteriorated to the point where the total personality had become involved. While in jail, prior to his transfer, he is said consistently to have acted and felt depressed, retarded and unruly. It is highly probable that an acute situational psychosis of the usual 'prison type' had a transient existence, but his present 'symptoms' are believed to be largely acting. It is doubtful whether any of his described hallucinations and delusions have been bona fide.

"He was able to conduct himself normally enough in the courtroom to obtain his release from a mental hospital and secure his return to the penitentiary.

"The diagnosis, therefore, in my opinion is: Psychosis with psychopathic personality, recovered. His return to the penitentiary is warranted."

This physician, therefore, while refusing to accept any of the patient's "symptoms" as genuine, believed nevertheless that a prison psychosis had existed; that the man's total personality had become involved in deterioration; and that he was or had been epileptic. The fact remains, however, that we do not know whether he was ever hospitalized before, nor whether he ever had convulsions or "fits" or "spasms" such as he has mentioned. In his narrative, he speaks of "spasms" as occurring while he was in jail (there is no mention of ever having been hospitalized because of them). It is altogether possible that he has simply added their history to his extensive "repertoire" of "symptoms"; that he has seen others have them, or has heard of others having them,

and thought that it wouldn't be a bad idea to tell about having had them himself. As for the "epileptic equivalents" represented by his rages, these have apparently prevailed all his life. The likelihood is that he had tantrums from the first time he ever met with any sort of frustration, and that these increased in scope and viodence as he grew older.

Malingering? The writer knew Cooksey from the first day he entered the hospital until the day of his discharge. Though I have seen and studied many cases of prison psychoses, and of malingering as well, Cooksey gave me the impression that his was a genuine prison psychosis with a rather classical mental content—the deceased appearing in his hallucinations, disturbing his sleep, etc. Even after reading the official reports which contradicted every one of the patient's statements; even when it was reported by attendants and observing patients that the man was deliberately faking the reaction; his psychotic-like reactions seemed, on the surface at least, rather genuine, showing what a thin and vanishing line separates the true psychosis from one that is simulated. The true condition was revealed by two reactions reported by the patient —the significance of which he did not appreciate. They were something more than slips of the tongue. The first, which is somewhat minor, is his "admission" that his "buddy" was the person who was co-defendant at the trial. Now, if Cooksey's story that the murder occurred at the ringside is true, there was no co-defendant. By admitting that there was a "buddy" and a co-defendant, he unwittingly gives away his knowledge that the murder occurred under the circumstances given in the official record. The second contradiction is a much graver one, the patient apparently having outwitted himself. Cooksey was of at least good average intelligence, but shrewder and "slicker" than the average man who is too honest to use shrewdness as a means to "get around" a situation. He had kicked around a lot in jails and prisons and could not fail to observe mental disturbances in prisoners, some of which, as we know, are quite on the surface. In federal prisons, such as Leavenworth, the criminal division of St. Elizabeths Hospital had a reputation for being a "soft spot" in which to do time. Cooksey had made up his mind to get to St. Elizabeths Hospital and the only way he knew how was by feigning insanity. But what kind of insanity? Had he been anything at all of a hysteric, Cooksey would have—as a genuine hysteric in his

place would have done—attempted to simulate an amnesia. Or, being of a projective make-up, he would have tried to embellish even an amnesia, by a claim that somebody else did the killing, and that—somebody else having escaped and the police needing a victim—he, poor Cooksey, is wrongly accused, a great, very great injustice. But that, Cooksey wouldn't attempt, it would be too simple, too easy to detect and to be caught at. To make sure that he wouldn't be detected, he planned a more complicated stunt. He would claim a reaction which is typical of a prison psychosis and is virtually foolproof against detection. He would claim that the murdered man annoyed him day and night, not giving him rest, etc. —a not infrequent phenomenon observed in prison psychosis. But which dead man—the real one or the claimed one? He feared that to claim the real victim, who was a white man, annoyed him, was a bit too dangerous; it might expose him, in the eyes of psychiatrists, to much undesirable probing. He had long ago decided to eliminate the real dead man from any mention or consideration. The thing to do, Cooksey thought, was to stick to the story of having killed a Negro because of an insult to the whites and claim that it was this Negro who bothered and annoyed him, especially at night. To the psychiatrist, that would have been entirely consistent had the murdered man really been a Negro, but entirely inconsistent if there was no dead Negro involved at all. By this action, therefore, Cooksey revealed, clearly and unmistakably, that the so-called psychosis was a manufactured one.

Insight: If this man ever showed an appreciation that there was anything wrong with him; any actual willingness, however slight, to be different and better, such evidence has never been recorded by statement in his record. At no place in his narrative does he ever take himself to task, concede error or short-sightedness, or give expression to any feeling of guilt or remorse. It is doubtful if at any time in his life he ever felt guilty about anything. It would seem as though he were "constitutionally" incapable of admitting guilt or even appreciating what it meant. His narrative is permeated with the spirit of exhaustless egoism. Here and there, a slight undercurrent of some sort of dissatisfaction with himself comes to the surface—a dissatisfaction which he soothes by telling lies about himself, according to which he *was* different, or at least had periods during which he was different. Thus, something within seems to crave the satisfaction that comes from

doing fine and generous things, so he imagines or rather claims that he *has* done them. Hence, as we follow his narrative, there emerges from the depths of his twisted nature some indication of a wish that he might have been different. This is never expressed consciously; it takes the form of fantasy and accounts for some of his lies. But never would he take the least step toward doing fine or generous things.

Only once, in connection with his long recital of homosexual activities, does he make any statement that betrays even the slightest sense of guilt. He speaks of having done "disgraceful things," but excuses himself on the ground of his youth. To the overwhelming social prejudice against homosexuality, he bows with this slight, and only half-hearted concession, perhaps because this sexual transgression is under the most strict social taboo; but upon every form of dishonesty and brutality he turns an approving eye, as long as it is he himself who has been dishonest and brutal.

Basic Type: While he does not suffer from one of the basic psychoses, there is nevertheless presumptive evidence that the patient went through some prison reaction—which is entirely understandable in the light of his situation. Predominantly, he appears to belong to the crystal pure type which the writer has previously described as idiopathic psychopathy (anethopathy), predatory aggressive type, with some mild intrusion of hysteric-like manifestations. All the evidence available seems to point in the direction of the reaction being basically constitutional, unmodifiable by any measure at present within our knowledge.

VI. *Finale*

The concluding question, then, seems to be: Was this man inevitably what he was, or was he what he was by reason of contributing circumstances? The answer is an equivocal one. Certainly it does not appear that he could ever have been a great deal better. His vicious nature seems to be indigenous. At the same time we cannot escape the impression that here and there in his material are to be found indications of potentialities for a certain degree of improvement, if such improvement had been favored by a constructive environment. Unfortunately, we have no actual knowledge of what his early environment was like; but everything leads us to suspect that it was thoroughly destructive, that it was consistently characterized by poverty, sordidness, ignorance and

neglect, and that its inevitable function was to make worse what was bad enough to begin with. "Thus, bad begins, the worst remains behind." Nothing would have saved this man from becoming a criminal; but many things might conceivably have saved him from becoming such a thorough criminal. He is like a rotten house built on a rotten foundation. Because of its foundation, nothing could have saved it from accident; but sound construction might have saved it from complete collapse. With nothing to withstand the influence of its defective foundation, its ruin was predestined.

Summary and Conclusions

The case study concerns a white man, 43 years old at the time of the study, who is serving a life sentence for murder. He is a pathological liar of the purest type and in the presentation of the material, full allowance has been made for the many inconsistencies, exaggerations and contradictions with reference to time, age, and place, with which the recital abounds. Withal, the very contradictions, checked against internal evidence, have provided definite clues to the basic make-up of the individual and his mental organization.

The Family and Early Life: The prisoner's family background is tainted. Though he describes a fine and a harmonious home, such descriptions appear to be in the nature of imaginative wish-fulfilling pictures rather than actual reproductions from memory, and represent at least an attempt to create a good impression. The weight of evidence is that he was brought up and lived in poverty and squalor as a member of the "lower low class," that his father was of a very jealous disposition, very cruel, a heavy alcoholic, and that his wife (the patient's mother) divorced him because of unfaithfulness. The patient may, therefore, be said to have come honestly by his disposition.

The mother is described by the patient as a very good mother. He reports that he was kind to her, but mentions nothing of her throughout the rest of the narrative, suggesting that his good words are only for appearances' sake. His attitude toward his siblings must have been one of complete indifference.

Though the patient claims parental interest and parental supervision of his childhood activities, as well as painting himself in the likeness of a model little gentleman and something of a hero,

everything else in the narrative contradicts this. It is difficult to imagine such strange fruit coming from a good environment.

Of childhood disease, he recites having "spasms" following measles—with much pain and many hard falls (epilepsy?). These "spasms" continued until his mid-twenties. He has later utilized the history of these when needing special care, no doubt having embellished it and exaggerated it beyond the original truth, if there were truth in it.

Though he speaks of having been graduated from high school and preparing himself for college, it is fairly definite that he has never progressed beyond the sixth grade.

Delinquency and Crime: He admits having run away from home once at the age of 11 and having lived first with another family and then with still other people for an unspecified period. During this period, he had a job on a boat; and, when he disagreed one time with his employer, he stole the man's property, including a watch. For this he was sentenced to the reformatory until he should reach the age of 21; obviously, he couldn't under the circumstances have finished high school and prepared for college as he claims.

His subsequent history is one of admitted thefts, larceny after trust, raising checks, assaults, cheating at gambling, robbing fellow-soldiers, etc., serving time on chain gangs; not hesitating, when convenient, to put the blame on someone else—not being concerned at all that someone else would be flogged for him. He also engaged in a good deal of boxing.

Instincts and Emotions: The long recital of fights, hold-ups, assaults, and predatory activity is accompanied by brutality which might suggest original aggression—untempered by any cultural concomitants such as remorse or guilt—rather than sadism, which is a conditioned form of behavior. He is of a belligerent disposition, capable of strong feelings of jealousy and revenge, given to explosions of violent temper and fury. On the other hand, throughout the story, one misses any account of his experiencing of the positive generous human emotions such as love, kindness, tenderness, etc., though he has tried to convince the physician, by purely verbal statements that he did this or that generous act, or loved this or that person—with nothing, however, to support such statements.

The chief emotions which motivate our patient are those that go with the need to satisfy immediate wants; and he is always in need and in want—he is pure instinct in action; unconditioned aggression. Sympathetic emotions are entirely lacking; those that he readily experiences are greed, hate and fear. He cannot exchange emotions or effect binding attachments.

Social Relations: Cooksey has no communal feelings, no group solidarity, no social interests whatever, he mixes with others only as he needs others. In all his interpersonal relations, he is always on the taking side, never on the giving side. He does not merely take; he grabs and grasps. There is a total lack of responsibility. He has no conscience, no guilt, no moral code. He has no goal, purpose or ambition; animal-like he lives only for immediate living. His life is a progressive series of antisocial acts and there is no type of crime of which he has not been guilty many times over. But for all the punishments that have been meted out to him, he has remained, in the manner of the true psychopath, unteachable and incurable, and his behavior is unmodifiable.

Sexuality: His sex life is characterized by virtual lack of control or ability to defer pleasure; it is all lust. He gives an account of a marriage, children, steady employment which, in the light of other material, appears more like a fanciful story than the truth. One is unable to explain why, under the circumstances he describes, his wife should leave him. He gives an even more vague account of two other marriages, and no mention is made of divorces.

His heterosexuality is excessive and he has missed little in the way of homosexuality and perversion. He admits pimping and homosexual prostitution. Not once in his life did he ever show the least affection for a woman or any sign of devotion. As is characteristic of the patient, he claims to have had relations with his father's second wife, suggesting a total lack of morals or inhibitions.

The Murder: While stationed in the Hawaiian Islands, he robbed and killed a white cab driver in cold blood. However, he stoutly denied this, asserting instead that he killed a Hawaiian because he heard him remark that all white men were yellow and could not fight, and that this infuriated him to the point of murder. His account is thus the very opposite of the official record and could be interpreted as a case of amnesia with displacement were

it not for the fact that amnesias take place in highly emotional settings—and this performance did not. His whole account gives every evidence of its being manufactured for the ostensible purpose of making him appear innocent.

Lying: In his lying, he is miles away from the confabulant, from the patient suffering from restrospective falsifications, or from the hysterical amnesic. He is even far from the pseudologue. He is a pathological liar, his lying being chiefly opportunistic and defensive and but little compensatory. Much of it is at the conscious or near-conscious level. Cooksey's stories represent a conscious attempt to deceive, coupled with a mental incapacity to appreciate the absurdity of his deceptions.

Withal, somewhere in the back of his crude and primitive mental life, there is some sort of vague wish that he might have been different, some pale recognition that things could be different. This is shown in the lies where he tries to present himself differently from what he was. This may have originated in a feeble superego which never finds expression in his daily life, in which he never tries to be different. But it does remain a silent part of his mental activity.

Diagnosis: Diagnostically, this man belongs to the group of idiopathic psychopathy (anethopathy) of the aggressive, predatory type. His so-called psychosis was a malingered one.

St. Elizabeths Hospital
Washington, D. C.

THE TELEPHONE---ITS USE AS A PSYCHIATRIC TREATMENT ADJUNCT

BY MILTON M. BERGER, M. D., AND BERNARD C. GLUECK, JR., M. D.

It is a proven principle in psychiatric practice today, that patients should be encouraged in every way to return from a state of withdrawal, or unreality, to a state of reality in which they are able consciously to face and satisfactorily work out their problems. It is the writers' conviction, based on personal experience, that controlled telephone communications can be a useful therapeutic adjunct of which the goal and effect place it in the same class as occupational therapy, vocational guidance, psychotherapy, and planned recreational activities. Several books written by former mental patients, attest to the fact that at the time of hospitalization most mentally-ill patients experience a certain "lost soul" feeling. The security requirements, which are part of the routine of most psychiatric hospitals, include the taking away of one's freedom of communication with the outside world. This loss of freedom contributes to the "lost soul" feeling at a time when its alleviation is most important. "What the insane most need is a friend."* Millions of Americans, including perhaps the patient now being admitted, have fought for the freedom upon which our whole concept of democratic government and existence is predicated. At the time of admission to a mental hospital, this freedom, previously taken for granted, is removed in one fell swoop. While permitting a newly-admitted patient to make or receive a phone call may seem like a minor, inconsequential act in contrast to the unshackling of chains and bolts by Pinel, it is, nevertheless, the writers' opinion that both acts are equally humane, justified, and necessary.

In their combined experience in city, state, and private hospitals, the authors have found that use of the telephone by patients on disturbed wards was rarely permitted, even in emergencies. At the private hospital where the authors are associated, it has been their experience that when telephonic communications are made directly by mentally-ill patients to those they love and feel close to, or to business associates, or to friends, such communications

*Beers, Clifford: A Mind That Found Itself. 1907.

can serve to hasten recovery as well as to relieve immediate episodes of acute anxiety and panic in schizophrenic, paranoid, depressed, and other disturbed mental states. It is necessary that these communications be controlled as to timing, direction, duration, and—sometimes—as to content. Privileged patients are customarily allowed fairly liberal use of the telephone in line with the permissive attitude of placing the fewest necessary restrictions on their activities. The purpose of this article, however, is to indicate how useful communication with the outside world may be, in the treatment of psychotic or other disturbed individuals confined in a closed-building milieu.

The resentment toward the hospital and the physician aroused in patients who are unable to make direct telephonic inquiry to ascertain the state of health of relatives and friends, to take care of their business affairs directly (Case No. 3), to check on the ability and reputation of their attending physicians at the hospital where they are incarcerated, to receive direct familial reassurance about the nature of their confinement, put an additional and, we feel, unnecessary barrier in the path of the therapist. At this hospital every effort is made to speed up the therapeutic process, so that the patient may be returned to a normal environment in the shortest possible time. This has a very important practical application in that it permits the utilization of private hospital facilities by moderate income groups, who can stand the cost of such care for a short time, but not on a long-term basis, as well as by those in a preferred economic situation; and it thus extends the scope of our therapeutic efforts. The judicious use of telephonic facilities in our opinion, is one of the important steps in this process.

The following brief case abstracts serve to illustrate the point we are endeavoring to make.

Case Histories

Case 1. M. H., a 20-year-old white, single, American-born girl from the South, whose home background was disturbed by the accidental death of her father when she was 12, was hospitalized at Stony Lodge because of a paranoid schizophrenic disorder. She had had two previous episodes at the ages of 15 and 18, but treatment was discontinued on each occasion before adequate psycho-

therapy could be administered. M. H. is an emotionally immature and unstable, dependent girl, lacking in self-reliance, with a tendency toward uncontrolled aggression alternating with withdrawal. She was in New York City studying fashion modeling at the time of her present illness, which followed profound homesickness and loneliness.

Arrangements for hospitalization in New York were made by the director of the school and the consulting psychiatrist following long-distance communications with the mother and family adviser. Because of previous friction between the mother and daughter, no attempts were made by the mother to come north at this crucial period. After receiving combined insulin and electric shock therapy for three weeks, M. H. made some improvement, especially insofar as apathy, anorexia, and intermittent agitation were concerned. Despite some phone calls to her mother which the patient was permitted to make, the mother was either unable to come north to visit her daughter or found suitable reasons for not doing so. An attack of influenza incapacitated the mother from writing. It was difficult to establish trust and rapport, and obtain co-operation from the patient during this period; she felt she had been shanghaied to the hospital, was being given injections of "dope" against her will, and that her mother was being kept from her by the physicians. Her attitude was markedly hostile and vindictive.

A telephone call to the mother, placed by one of the authors in the patient's presence, related the exact state of affairs as far as the daughter's mental health was concerned. The mother was asked to reassure the daughter as to the legality, propriety, and necessity of her hospitalization and treatment, as well as the need for M. H.'s co-operation in all our endeavors if she wanted to hasten her own recovery. The patient was then permitted to speak to her mother for 20 minutes. Reassured by the direct conversation and the answers received to all her questions, the patient felt closer to reality by being able to catch up with the news concerning other members of her family and her home-town friends. Many of her paranoid ideas were immediately dispelled. At the termination of her telephone call, she embraced the physician and was extremely grateful and apologetic, and promised full co-operation in the future as she believed her distrust was no

longer justified. Insulin and electric shock therapy were continued for another two weeks and the patient continued to show a marked improvement and became amenable to psychotherapy.

Case 2. M. J., a 30-year-old, single, American-born woman, previously hospitalized at another institution because of a psychosis with predominant paranoid and depressed trends, was later transferred to Stony Lodge. Following a lengthy course of insulin coma, electric convulsive therapy and psychotherapy, the patient made a complete recovery and was later employed on the hospital staff as a research worker. She wrote that during her first hospitalization she was profoundly hurt by the refusal of the physicians to grant her repeated requests to use the telephone. During her stay at Stony Lodge, she showed marked appreciation and psychotherapeutic response when permitted to make phone calls to her family, toward whom she had a very ambivalent attachment. This was based on her rigid compulsive desire on the one hand to feel and express compliantly the closeness that is considered proper; and on the other, to give way to unreserved, hostile, aggressive impulses because of the repeated intermittent episodes of irrational parental rejection.

M. J. further wrote, in reference to her desire to telephone, the following: "I remember the feeling of being cut off from the entire world—of being in a prison being punished—the fear of never being able to get in touch with anyone who'd take an interest. Locked doors—an attendant always with you night and day, watching every move. She always seemed a spy. The feeling that everyone was suspicious of everything you said and did, and the sly way you felt you were acting. Above all, the feeling of aloneness, of not having anyone. You wrote letters and received them, but the ones you wrote you censored yourself—if they watched you so carefully they must read your letters and not send them out if they read detrimental to the reputation of the place. You received letters, but they didn't seem real—a part of the world which wasn't real to you. Reading them, you'd find a sentence that seemed as if it wasn't a complete one—they were trying to hide something—and so you'd worry. You wanted to speak to a person you loved and trusted—hear their voice—the tone—so you'd know. People outside seemed so dreamlike. You wanted more than writ-

ten words to reassure yourself that you weren't imagining them. To telephone was *verboten,* to receive calls was *verboten.* Finally you told the floor nurse you'd find a way of committing suicide if you couldn't call home. Permission came through. The telephone seemed a strange instrument, and you were so nervous using it you almost forgot what to say. But you spoke *yourself* to your family. You heard their voices, and for a while the lost, neglected, unreal feeling was lifted. I think that being allowed to use the phone only because of making a suicidal threat was poor psychology on their part."

Case 3. A. K., is a 62-year-old, single, American-born, well-educated woman, who has shown chronic signs of schizophrenia during intermittent hospitalizations for the past 15 years. At present, she is hospitalized because none of her family can endure having A. K. live with them for any great length of time in view of the episodes of suspiciousness, anger, and hostility which she experiences, and the name-calling which she directs at all who come near her at those times. The patient believes that people are taking advantage of her, especially with regard to financial matters; and also, that she is purposely left out of various activities of the patients. At such times, she becomes markedly disturbed emotionally and insists on being permitted to telephone her bank to check on her balances, and also to telephone her sister to complain of the treatment she receives at the hospital. On the occasions when she has not been permitted to phone, she has remained enraged and has become even more paranoid. However, when permitted to phone despite her disturbed condition, she was greatly relieved after harassing her bank manager and her sister, and has then become much more pleasant, tractable, and co-operative. She remains in this state for two or three weeks until the paranoid psychosis again becomes more manifest.

Case 4. R. Y., a 59-year-old, widowed, American-born, "middle-class" woman, was admitted in a state of involutional depression with agitation and some delusions. The most prominent of her delusions was that she had been pregnant for five months, and she maintained this belief despite repeated reports to the contrary by competent gynecologists. The delusion was based on a reality situation which occurred five months before her hospital admission when she had had sexual relations with a life-long male friend.

during the course of which, the contraceptive device was defective. In addition to other concerns regarding the outcome of this "pregnancy," the patient was worried for fear that her son, who had brought her to the hospital, would desert his now contemptible, ill-behaved, problem mother. On the day following admission, though she had been markedly agitated all day while relating all this, the patient received tremendous relief and pleasure when she was permitted to speak to her son who had phoned to inquire about her condition. She knew then that her son had not deserted her, and this feeling was a good support for her during the subsequent course of therapy.

Case 5. J. P., a 22-year-old, single, American-born man, a college sophomore who was a navy veteran, was admitted to the hospital for a course of combined insulin and electric convulsive therapy on transfer from another private hospital where such therapy was not available. A definite paranoid schizophrenic, with numerous bizarre delusions of all types, as well as auditory hallucinations and a profound intellectual and emotional disturbance, the patient manifested continuous and extreme restlessness. On the day following admission, and on numerous occasions after that, the patient was permitted to phone his mother. J. P. stated that he suffered from a condition of "assumed claustrophobia" which he believed he inherited, as his father experienced claustrophobia and talked about it frequently. The patient, who had been close to his father, had apparently identified with him in many ways. J. P. stated that being permitted to phone home gave him immediate release from "assumed claustrophobia." As a result of the relief of this symptom, a manifestation of his general, overwhelming anxiety, the patient was much easier to handle than he had been at the former hospital—according to the report which accompanied him.

Procedure

Stony Lodge patients request permission to make phone calls directly from one of the physicians or indirectly through a nurse. Those patients who are obviously disoriented, highly excited, and completely unstable emotionally, are usually refused permission. However, if there is one specific problem which seems to be agi-

tating the disturbed patient, and it is the physician's opinion that this matter or conflict can be cleared up by communication with a relative, permission for such a call may be granted. The patient is usually asked whom he intends to call and what he intends to discuss. Separate permission must be granted for each call. Though on occasion the patient's statement concerning his planned call may prove to be untrustworthy, this is not considered reason to forbid all future calls. The decision regarding each separate call rests on the psychotherapist's present opinion of the patient's present status.

If the physician feels that the call may disturb the recipient because of its unexpectedness and its content, he may at his discretion arrange to speak to the recipient first, either in front of the patient, thus indicating his complete frankness, or—if that is inadvisable—he may do so from his office. After coaching, encouraging, or cautioning the recipient, as indicated by the patient's behavior, the physician has the patient connected through the switchboard. If the physician believes that the duration of a specific call should not be too long, he instructs the operator to cut in after three, five, or 10 minutes, state that the circuits are needed, and if necessary, disconnect the call. The patient never makes outside calls directly; all calls go through the master switchboard. When the stability of the patient is considered rather doubtful, so that his statements may be adversely interpreted, the switchboard operator or the physician listens in on the call and is able to disconnect it, if it becomes necessary. If the patient becomes agitated while making the call and it is believed that the recipient may be unduly upset, the physician can have the patient disconnected and then speak to the recipient, to reassure him and to review the call.

Patients who insist on privacy can obviously have this when the aforementioned listener-technique is utilized. At Stony Lodge, patients are permitted to use the telephone in the nurses' office where, as is customary in mental hospitals, all medications are kept in locked cabinets and all charts are put away so that they cannot be seen by the patients. Observation of the patient during the telephone call can be made through a glass panel in the door of the nurses' office.

SUMMARY

1. The authors report the value, as a therapeutic adjunct, of controlled telephonic communications by patients, in establishing rapport and facilitating psychotherapeutic response.

2. Cases are presented which illustrate the function of this adjunct in alleviating many episodes of anxiety and panic in schizoid, paranoid, depressed, and other disturbed mental states.

3. Freedom to use the telephone clears up, at least temporarily, the "lost soul" feeling associated with mental illness requiring hospitalization in psychotic patients. By thus encouraging and permitting the patient to face reality, therapy is speeded and the duration of hospitalization shortened.

Stony Lodge
Ossining, N. Y.

A CONSIDERATION OF THE ACUTE SCHIZOPHRENIC EPISODE

BY GERALD J. TAYLOR, M. D.

Our ancient social dicta hold that wisdom increases with age. By repetition, and according to our modest intelligence, we know that knowledge should increase with experience. To the younger psychiatrist, originally surfeited by the sheer mass of institutional material arranged in the furrows of descriptive psychiatry, there comes, through the experience of many, many cases, further understanding of these old classifications and further conceptions and widenings of their original borderlines. So it is that one comes to his individual diagnostic considerations—his own observations, which approach dogmatism and associated infallibility; and, so it is that one adopts varying understandings of the immutable and rigid categories which are the runways of mental disorders.

Several months ago, the writer had the opportunity of observing simultaneously three exceedingly interesting and similar cases. Understanding of them can best be achieved by illustration.

Case 1

E. B. was a white, single man, aged 22, a Roman Catholic, of common school education, a merchant seaman, born in Maine of French descent. He was admitted to Bellevue Hospital, October 19, 1947, after trying to jump off the 149th Street Bridge over the Harlem River. On admission he was agitated and displayed an inappropriate affect, his speech was disconnected and incoherent, he displayed ideas of reference and was experiencing auditory hallucinations. He said everyone was talking about him and calling him "queer." His physical condition was good.

This patient was admitted to Manhattan State Hospital five days later. Anamnestic data obtained from a step-sister indicated that the man was the youngest of four children. His father had died when the patient was 16 months old. At the age of 17 E. B. had joined the merchant marine; and he served there throughout the recent war. He was believed to have been on several torpedoed ships. Much of his time in the maritime service, E. B. was with a male cousin to whom he was strongly attached. He was also very "close" to other members of his family. He was said to have felt

inferior to his siblings. He was fond of hunting and fishing, preferring to wander the woods by himself.

E. B. had returned from the sea in October 1947 and had announced to his family that he was planning to be married. He discovered, however, that in his absence his "girl" had become engaged to another man. On October 14, 1947, he went to Portland, Me., ostensibly for a physical check-up; and it was five days later that he was picked up trying to jump off the bridge in New York City. On admission to Manhattan State Hospital the patient was paranoid, self-accusatory, depressed, and underproductive. He admitted hearing voices saying he was "queer," and he admitted having suicidal ideas. He was noted to be of athletic build, and his physical condition was essentially normal, except for excessive sweating of the palms of his hands. More detailed examination revealed that he had begun drinking soon after leaving ship, and had begun to hear voices of his family members accusing him of having performed cunnilinctus on a girl friend. When the patient came to New York from Maine, he felt that everyone wanted to kill him. He later heard people saying he should commit suicide.

E. B. was correctly oriented, his sensorium was clear, but his insight was impaired. The patient was transferred to the shock service seven days after his hospital admission and was observed to be apprehensive and depressed. He stuttered moderately, admitted auditory hallucinations, and said that everyone knew all about him. He was felt to exhibit some insight. This patient was seen daily and received several sodium amytal interviews. It was revealed that he had lived the typical sailor's life with considerable carousing in every port. He denied having had any homosexual experiences. Twenty-five days after hospital admission the patient had improved substantially. He said that his auditory hallucinations had ceased soon after coming to the shock service. He suspected that the voices he had heard were real. He admitted drinking to excess for a long period of time. The writer considered him to be a case of dementia præcox, paranoid type, under the criteria of the official system of classification. One month after admission, the patient was officially diagnosed as a case of psychosis due to alcohol, acute hallucinosis, recovered; and his discharge was recommended with the statement that "the patient showed no evidence of psychosis," and "his uneasiness and tenseness were felt due to his inexperience and embarrass-

ment before an audience." The recognition was made that "many cases diagnosed as alcoholic psychosis, often eventually become full-fledged schizophrenics."

A Rorschach study on this patient by a student observer gave "indicative signs of schizophrenia."

Case 2

W. W. was a white, single man of 24, an Englishman, a Protestant, and a merchant seaman. This patient was admitted to Bellevue Hospital, October 5, 1947, after a suicidal attempt in which he slashed his throat from ear to ear. The injury was of such severity that a tracheotomy had to be performed. At Bellevue, the patient was considered co-operative, but tense. He admitted having auditory hallucinations and ideas of persecution. He stated that "everyone in the hospital accused him of being a homosexual." During his stay in Bellevue, the patient developed delusions of grandeur. He was transferred to Manhattan State Hospital 19 days after admission to Bellevue.

Anamnestic data obtained from the patient himself revealed that he had been born in Plymouth, England, in 1922, the third of seven children. He had attended school until the age of 18, had been apprenticed as a mechanic and had subsequently been sent to Alexandria, Egypt, for two years. While in Egypt the patient had a love affair with an Egyptian Jewish woman, and, desiring to marry her, applied to his medical officer to become circumcised that he might become a Jew. The patient's request was refused, and he was transferred to Port Said, where he had an erratic work record and became involved in some "petty graft." He had been working on ships, since April 1946, as a fifth engineer. His chief difficulties started about three months before hospitalization, when in an Indian port he became intoxicated, stole five cases of whiskey from the ship's stores and placed them in his cabin. He jumped ship several days later, and was subsequently picked up for desertion and returned to his ship. The patient's ship then set out for the United States. During the voyage the patient began to feel that the captain and third mate of the ship had him in their power and were planning to book him for desertion when the ship returned to England.

W. W. later began to feel that his mind was "open to the world," and he began to hear voices. In the month journey from Port

Said to Boston, he had taken no alcohol, but, on reaching Boston, he became intoxicated twice in a few days. His ship came on to New York City, and on arrival there the patient was seen at Long Island Hospital, where he was diagnosed psychoneurosis, anxiety, severe, or possibly early schizophrenia, paranoid type. He was placed in the Times Square Hotel to await shipment back to England. While in the hotel he continued to be bothered by voices calling him "homosexual," and he thought he heard the voice of the third mate asking for a doctor to see the patient. W. W. was so disturbed by his hallucinations that he wandered from the hotel, not knowing where he went, and was finally picked up by the police after attempting suicide in a synagogue on East First Street.

W. W. had had his first heterosexual contact at 17, and had had many contacts since that time. He denied ever having had any homosexual experiences. He had started drinking at 17. A letter from the patient's father stated that the boy had had an apparently normal infancy. In school he had been considered a brilliant student. As a child he did not care to leave the house or play children's games. In high school, W. W. had at first been in the upper three places of his class but later fell back to the last three. At 16 he was placed in a factory. W. W.'s father was required to enter military service, and subsequently the boy was said to have "run wild." At the age of 20, he had been restless, disinterested in his job, and had been considered rather grandiose at times. On admission to Manhattan State Hospital the patient was observed to be preoccupied with bodily symptoms and was especially concerned that he had a persistence of an old case of gonorrhea, which had been adequately treated several times. He was seclusive and was spontaneously productive with great attention to detail. One observer considered the patient's affect appropriate to mental content. He repeated his story of auditory hallucinations and ideas of persecution; he was correctly oriented; and his memory was intact.

W. W. was of asthenic build and in good physical condition. His laboratory studies were negative. For some days after admission he continued to be idle, seclusive, depressed, and self-absorbed. Within three weeks, however, he had become friendly and brighter. He came to feel that he had misinterpreted remarks people were making and had referred them to himself. He felt that his mind had "cleared up." The patient was transferred to the shock serv-

ice, where he continued to be observed. Everyone who made contact with the patient found his conversation highly interesting, because he seemed to express unconsciously many of the factors dynamic in the formation of his persecutory ideas. He came to feel that the voices he had heard were real; but whether he had really heard them or imagined that he had heard them, he couldn't say. The patient could never recall the events immediately surrounding his suicide attempt. He continued to improve in the "social sense," but under continued observation it seemed that his affect was silly and inappropriate.

This case was considered by the writer to be an acute paranoid schizophrenic episode, but the official diagnosis was that of psychosis, due to alcohol, acute hallucinosis, with the statement that "this was a psychosis in a young man with an alcoholic history characterized by acute onset with terrifying hallucinations, which cleared up after a few weeks." It was again recognized that "some cases of acute hallucinosis are schizophrenics, but it is felt in this case there was no evidence of schizophrenic process."

The patient was discharged as recovered one and one-half months after admission. Concerning a Rorschach study by one observer, it was recorded: "no evidence of underlying schizophrenic process."

Case 3

J. B. was a colored, married man of 27, a Protestant, employed as a clerk. This patient was admitted to Bellevue Hospital, October 5, 1947, having been brought from his home by the police. He was found to be hallucinating and delusional, and displayed a lack of insight and judgment. His physical condition was good. The patient was transferred to Manhattan State Hospital, six days later. On admission there he was quiet and co-operative. He displayed a paranoid trend, in which he felt that he had been given "dope" by his wife and others, because his wife was "pregnant by another man." He said that he was being "worked on by a brain analyzer" and he was afraid that he was going to be killed. He also felt that he had foreign bodies in his body.

Further examination revealed that J. B. had drunk to excess for some time because of feelings of inferiority. He had been drinking steadily for a week prior to admission and had been eating little. He was correctly oriented. Anamnestic data obtained

from J. B.'s wife revealed that she had left him a week before his hospitalization because of his excessive drinking. She said that the patient had been drinking to excess for a long time. The patient was described as good-natured, when sober, but "vile" and destructive when intoxicated. Physical examination of the patient revealed acne-form lesions of the face, hands, arms, and back. Laboratory studies were negative.

This man was transferred to the shock service 13 days after admission. On that service he was noted to be overproductive with attention to minute details. He admitted having auditory hallucinations and persecutory ideas, but said that the hallucinations had ceased soon after hospitalization. J. B. blamed all of his difficulties on drinking, and would not agree that he had been mentally ill. He said that he was nervous and run-down from excessive drinking and from not eating properly. The case was diagnosed as one of dementia præcox, paranoid type, and this diagnosis was accepted.

A Rorschach study by one observer gave: "findings found in records of alcoholics, but also findings pointing to a consideration of a schizophrenic process." Sodium amytal interviews revealed the information that the patient suffered from feelings of inferiority, jealousy toward, and dependence upon, his wife. He said his wife had left him in 1946, because he preferred to look after the house and do his own cleaning and cooking. He said that he had always been shy, found difficulty in making friends, and avoided social intercourse. J. B. was discharged to convalescent status 58 days after admission to the hospital, as much improved. At the time of leaving the hospital, the patient stated that he had actually heard voices before hositalization, but couldn't state if they were real. He admitted that he was probably mentally ill when first hospitalized. His affect was somewhat flattened, he displayed no abnormal ideas, and he insisted that he was never going to drink again.

Although these three patients were on the male shock service in the hospital, none of them received any form of shock therapy.

* * *

Now, what is meant by the acute schizophrenic episode? The writer believes it to be a schizophrenic psychosis of the paranoid type, characterized by the sudden appearance in an apparently "normal" individual of delusions and hallucinations of a paranoid

nature, and a remission as complete as the onset is sudden, to the status of the afore-mentioned "normal" individual. The writer thinks there will be agreement that at their heights the psychoses of the patients described were quite literal pictures of paranoid schizophrenia. And it will quickly be added that the course of these cases is one of the diagnostic criteria of the alcoholic paranoid hallucinatory episode. That contradiction leads to a discussion of the "why" for this heretical "what"—a consideration of the dynamic processes involved.

The groundwork in all these cases was traditional—all three individuals can safely be classified as schizoid personalities. In such a ground, the writer believes, lies the seed for the schizophrenic psychosis—and the breaking of an ego with reality allows its flowering forth in acute fashion. One can speculate as to why men join the naval and merchant marine services, both of which offer refuge for the schizoid personality, and, too, satisfy unconscious homosexual drives. It is more than an interesting coincidence that the first two cases mentioned were of seamen, who had homosexual hallucinations. Such projections in these two cases are, to a measure, conditioned by the patient's environment for both patients noted that homosexuality was a frequent subject for bantering discourse between mariners. In the first two cases, hospitalizations followed suicide attempts. In the second case the suicidal attempt was high dramatic, but dynamically "sound." It was an attempt by a Christian man who had been refused in a request for circumcision to become acceptable for marriage to an Egyptian Jewish woman. This young man attempted to sever his head, of which the symbolic significance cannot be denied, by slicing his throat from ear to ear in a synagogue. The frequently bizarre aspects of suicidal attempts among schizophrenics are rather well known.

In all three cases there is a long history of excessive alcoholism. This excessive indulgence in alcohol is to be considered a symptom of disease, and not a disease in itself—as is homosexuality a symptom. In these cases all three individuals suffered from feelings of inferiority and inadequacy. Alcohol had undoubtedly fortified for some time their egos' hesitant association with reality. But alcohol can soon turn from the role of friend to enemy; and, in the person weakened by poor food intake during the debauch,

will further undermine the organism to the point where ego and reality are no longer in contact, and consequently the phenomenon known as psychosis appears.

In Cases 1 and 2 there were also inciting factors evident. In Case 1, the patient was turned away by a "fiancee." Alcohol was resorted to, but failed—hallucinations and delusions appeared—and finally the attempted complete break with reality, the attempt at suicide, was made. In Case 2, the patient was facing punishment and disgrace for stealing and for jumping ship. Alcohol again was resorted to, but failed—hallucinations and delusions appeared—and a highly dramatic suicidal attempt sought the complete break with reality.

In all three cases, institutionalization removed the patients from disturbing environments to which their egos were not able to accommodate, and also removed them from recourse to alcohol, which in excessive amounts, had weakened their organisms as units and thereby their ability to sustain contact with reality. While hospitalized, the patients—that is, their egos—were able to reconstitute their forces rapidly for that disputed "contact" with reality, and they gave semblance of recoveries from their psychotic episodes. We should recognize these as no more than "social" recoveries, for these are individuals suffering from constitutional schizophrenic processes. These are individuals, who, after their brief episodic outbursts, can quite satisfactorily return to a society which harbors their innumerable counterparts.

The concept of an acute schizophrenic episode finds little mention in textbooks of descriptive psychiatry. Fenichel, however, does believe in the existence of such an entity, and accords it mention in various places throughout his book, *The Psychoanalytic Theory of Neurosis.*

Such is the telling, and here a repetition of the thesis: In the pattern of psychiatric occurrence there are cases involving members of so-called "normal" society, which are socially nonmalignant cases of schizophrenia. In instances initiated by traumatic emotional experiences and/or, abetted by toxic agents, such as alcohol, these individuals may suddenly exhibit full-blown pictures of the paranoid type of schizophrenia, characterized by hallucinations and delusions, lack of insight and deviation in affect. Under hospital conditions, and with the benefit of psychotherapy and shock therapy, such patients display a rapid improvement and

progression to the point of remission and are considered returned to "normal" status. Examination of the cases often reveals many of the criteria essential to schizophrenia from the standpoint of descriptive psychiatry. A contemplation of these cases is a consideration of the acute schizophrenic episode.

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PSYCHIATRIC ASPECTS OF A NEW GRAPHOMOTOR PROJECTION TECHNIQUE*

BY RAYMOND H. GEHL, M. D., AND SAMUEL B. KUTASH, Ph.D.**

This article presents preliminary interpretive information relative to a new graphomotor projection technique and is based upon material drawn from a six-month study of approximately 200 subjects who came to the attention of the authors in the course of clinical work at a large psychiatric hospital and an out-patient mental hygiene clinic. A scattered sampling of 50 subjects who never required psychiatric treatment was also collected.

Description of the Method.† The subject is seated comfortably before a desk or table, a pencil and two sheets of paper (8½"x11") are given to him and he is then blindfolded. He is told to allow his hand and mind to "go freely" and to try not to plan to produce anything in particular. He has five minutes to work on the first sheet of paper and five minutes on the second. If the subject makes or writes any geometrical figures, letters, numbers, pictures, words, or form designs, on Sheet 1, he is instructed when Sheet 2 is presented, not to make or write any numbers, pictures, etc. (depending upon which of these structured items he has produced on Sheet 1). This procedure serves as a sort of "testing the limits," to see if the subject is capable of less structuring of the performance. After the performance is completed and before the blindfold is removed, the subject is requested to tell what he made on the paper and what his thoughts were during the test. The blindfold is then removed, and he is asked to identify any structures in the productions that he can see or imagine. He then associates freely to the content identified. The examiner records initial reaction-time, spontaneous comments made by the patient, the examiner's own qualitative observations on the subject's performance,

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†A full description of the technique of administration and scoring is provided in another article now in press and in the mimeographed Manual and Scoring Blank available on request to the authors.

number and kinds of pauses and breaks, amount of pressure on the pencil, speed and quality of the movement, types of markings, number of times the pencil goes off the page, content identification time, and certain other items.

Rationale. The method aims at revealing contrasting and fundamental layers of the personality—deeper layers, exposed and expressed through amorphous myokinetic graphic productions, and layers closer to consciousness, revealed through verbal association, visual perception, and projection. Through studying simultaneously these aspects of the personality as well as ascertaining a total impression of the production after taking into account all of the scored factors mentioned, one obtains a dynamic global picture of the personality in action.

The vague nature of the directions permits the subject wide latitude in expressing himself graphically and thus provides an outlet of his own choice through which his inner emotions, reactions, and thoughts are projected.

The blindfold serves the purpose of excluding visual impressions and their accompanying distractions, thus facilitating the expression of inner promptings, uncontaminated by perceptual responses to these external visual stimuli. The subject is confronted with himself more completely. The same principle, that of removing distracting stimuli which would interfere with the patient's freedom of association, is made use of in the psychoanalytic method.

Graphic productions of an amorphous nature, in contrast to more structured graphic forms of expression such as figure drawing, copying of designs, and handwriting, leave less room for conscious censorship and the application of previous learning-patterns. A visible record is secured of the underlying personality. This record can be easily utilized for following the patient's progress in treatment.

The material is capable of application by psychologists and psychiatrists from all schools of psychiatric and psychological thought and does not depend upon the adoption of one orientation. The test is relatively simple to administer, consumes only a short time, and gives immediate insights into the subject's personality-structure and its defenses. Experience has shown that there occurs,

after completion of the test, a readiness upon the subject's part to express himself more completely in regard to his personal life and problems, thus affording excellent therapeutic leads.

Sample Records

Records I and II, taken from two individuals who had never received any hospital, clinic, or other psychiatric treatment, demonstrate the nature of the graphic productions obtained. These subjects are moderately well-adjusted to our society and hold responsible professional positions.

Record I was produced by a 49-year-old white, single woman while Record II was given by a 36-year-old white, married man. Both show free-flowing movement with much whirling, circular motion of moderate speed. The pencil pressures are moderate and uniform, being heavier in the male record. The major portions of the sheets are filled showing high aspiration levels. There is continuity, directional change, and a smooth rhythmic quality. The subjects did not find it necessary to structure the production or produce anything concrete or definite. Subject I identified 15 items of content, all seen after the blindfold was removed. She said she got a pleasurable, kinesthetic feeling and thought of physical motion such as waltzing and swimming. Subject II identified 10 items of content only one of which (that labelled No. 3) he was aware of having made. He verbalized that he felt relaxed and got a pleasurable sensation, as if he were conducting an orchestra. He was also reminded of ice skating and of dancing. The primary sensations of both subjects were those of rhythmic movement.

There were very few breaks or pauses in these records. The pencil rarely went off the page, and when it did, the subject quickly brought it back. There were no signs of marked anxiety in the subject's behavior and no delayed reaction-times.

Interpretation of Specific Psychomotor Patterns

Here are presented qualitative observations concerning various aspects of performances which the authors have found to have interpretive significance. It is only when a given phenomenon appears in grossly exaggerated form and is the outstanding characteristic of the production that it is considered to have pathological significance.

A complete personality study requires the consideration of all of the scoring factors in their dynamic interrelationships. An item appearing in one context may have different significance from that attributed to it in another configuration. Heavy pencil pressure, for example, in a record where the amount of space filled is restricted and the movement slow and tremulous, might reflect marked tension and anxiety with a bottled-up affect. In a context where it appears together with large, fast movement on a sheet that has been almost entirely filled, it may signify aggressiveness and drive, or hypomania. Global interpretation and a consideration of all the features of the production as a Gestalt is important for arriving at diagnoses.

Number of Breaks. A break is defined as any stopping of the continuity of the marking and the beginning of a new continuum. In many of the psychotic patients, the performance was characterized by a tremendous number of breaks, resulting in choppy, lineal, productions. This is illustrated in Record III, Sheet 1.

This patient, diagnosed by the hospital psychiatric staff as an over-ideational schizophrenic, shows by his performance on the *Gehl-Kutash Test,* a fragmentation of the personality reflected in choppy, unstructured, interrupted, movements. The affective flow is constantly broken. There is no continuity of the lines. The breaks are not related to the degree of structuring and seem to be the result of blockings, interruptions, and/or disorganization of the continuity of the motor promptings projected. On *Sheet* 2, where the content identified is labelled, it is apparent that the patient sees a great number of structures in the production. Most of these are quite far-fetched, reflecting a pathological exaggeration of his imagery and ideation.

Number of Times Off Page. Going off the page, and the subject's reaction to this occurrence, depend upon his spatial and geometric perception—which gives some indication of his orientation to the environment. Record IV is that of a disoriented schizophrenic patient who had fixed paranoid delusions and believed that he had been "ordained as a 70-degree Mason, Commander-in-Chief of the world." He asserted that he could control all worldly events and was quite expansive. He broadcast to the world through the hospital ventilators. A course of insulin and electric shock therapy was ineffective.

The page cannot contain this patient. He needs more space. He keeps going in one direction—down and to the right. He goes off the paper and continues to make lines on the desk blotter. He does not realize he is off the page. When his hand is put back he goes off the paper again. That he is expansive and aggressive can be seen by the heavy pencil pressure and the rapid and large movements. He labels the content "highway" and "cross triangle line." There are frequent breaks. He does not take into account the size or outline of the paper and does not use his left hand to orient himself to the paper or its outlines.

Speed of Movement. Fast movement is found in excited and manic subjects where the affect is impulsive and uncontrolled. Conversely, very slow movement is found in depressed patients or extremely cautious and over-controlled subjects. Changes in speed during the performance are related to mood swings.

Record V is that of a hospitalized patient diagnosed as manic-depressive psychosis, depressed. His performance is marked by extremely light pencil pressure, very slow movement, underproduction, and little rhythm. The hand moves slowly in one continuous line, at times barely touching the paper. He calls it "a lot of scribbling," says he drew nothing, and gives no associations.

Kind of Movement. The kind of movement, whether it is smooth or spasmodic, regular and rhythmic, or irregular, seems related to whether the affect is released evenly or in an interrupted fashion.

Record VI is that of a neurotic woman in good contact and able to perform her daily duties as receptionist in a physician's office. The movement is smooth, wavy, and rhythmic but structured into the same repetitive pattern.

Record VII, Sheets 1 and 2, and Records VIII and IX, illustrate spasmodic movement and were produced by schizophrenic hospital patients. They show variability in direction, and loops; and in Sheet 1 of Record VII, the content is seen as paranoid in nature. Patient IX verbalized that he made zigzags. The irregularity and loops which are seen contrast with this and show the distortion in these "zigzags."

In Record X, Sheet 1, the subject gave a highly structured performance. When directed not to make anything specific on Sheet 2, he produced a pattern similar to that seen in the schizophrenic

records just noted. This revealed the underlying affective disturbance and indicated the deeper pathology when the defenses were penetrated.

Pressure on Pencil. This factor has been found valuable in reflecting passive-aggressive patterns. Heavy pencil pressure is found most frequently in aggressive individuals and seems related to masculinity. At times, the pencil pressure in hostile and paranoid patients becomes so great that the paper is torn by the pencil. In some anxiety states, the pencil is gripped so firmly that the pencil pressure is heavy. These are distinguished from the overtly aggressive by reason of the fact that the movement is restricted and tremulous. Light pencil pressure is found in passive subjects and in depressed patients (See Record V). Variability in pencil pressure within one production may indicate a passive-aggressive conflict or may reflect specific tensions or anxieties.

Types of Markings. These are scored according to whether they are linear, angular, zigzag, circular, waves, or any combination of these. There seems to be a high correlation between linear markings and flattened affect. Records XI and XII are both from deteriorated hospitalized schizophrenic patients with markedly flattened affect.

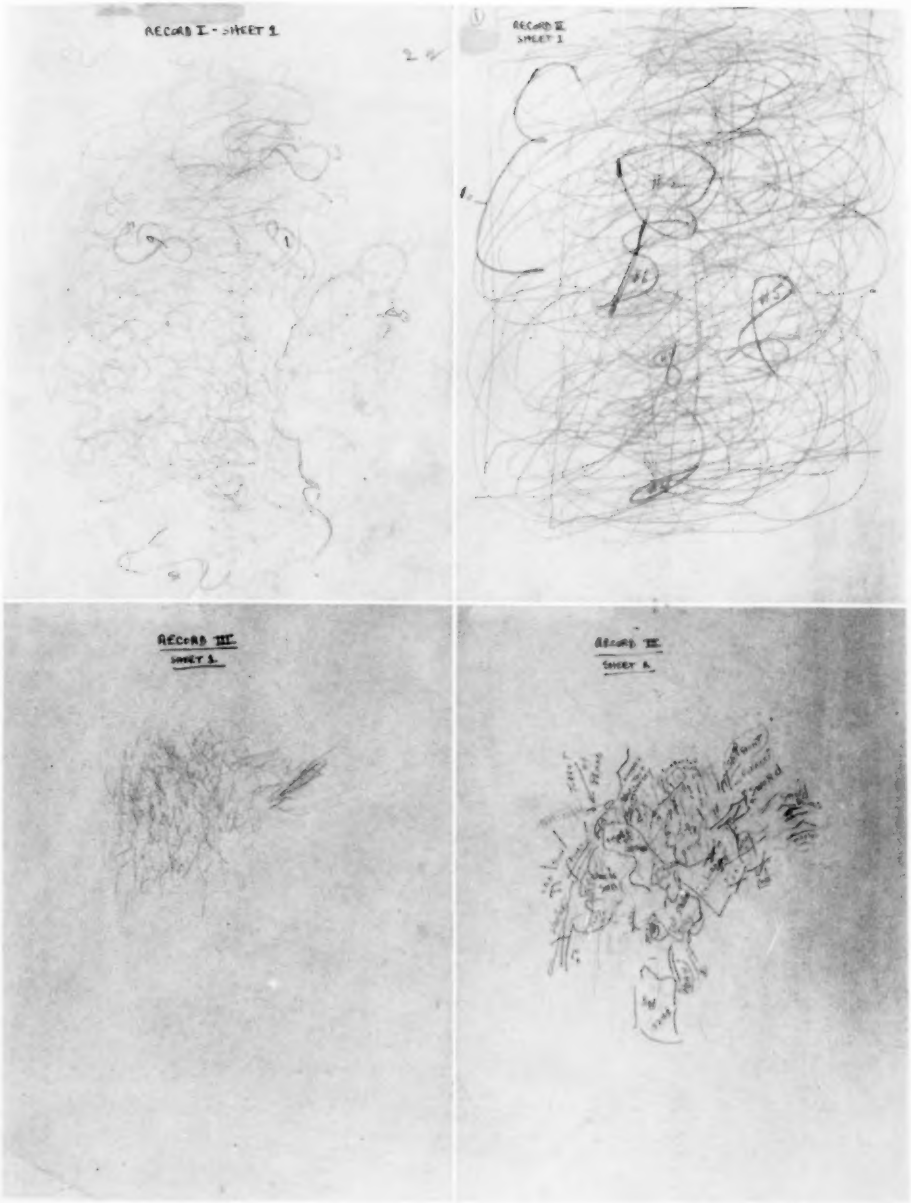
This type of performance contrasts markedly with the wavy markings in Record VI, the circular markings in Records I and II, and angular and zigzag markings in other records.

Amount of Space Filled. This factor is related to expansive-constrictive aspects of the personality. Record XIII of a markedly coarctated subject whose affect was bottled up shows that he can only operate in a limited area. In Records I and II, are seen an absence of constriction since most of the page is filled. Record XIV is that of an individual who attempts to operate in a large area but fills it only sparsely.

Case Studies

The following case studies illustrate the application of the interpretive leads just enumerated.

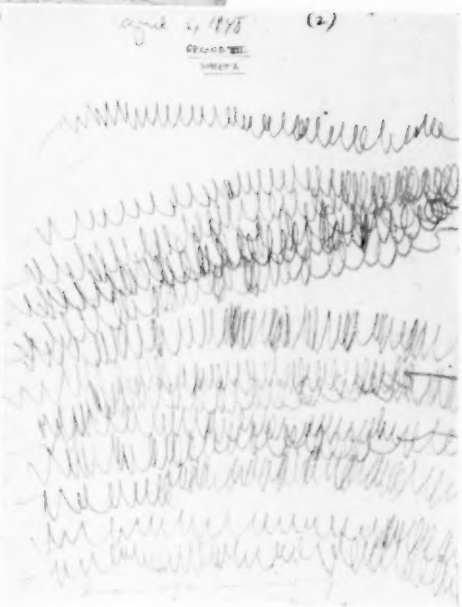
A. J. is a 24-year-old, white man, a college junior, who showed early clinical signs of a schizophrenic process accompanied by

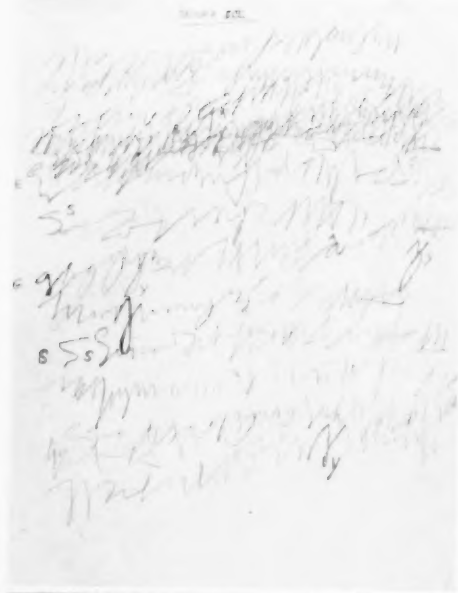


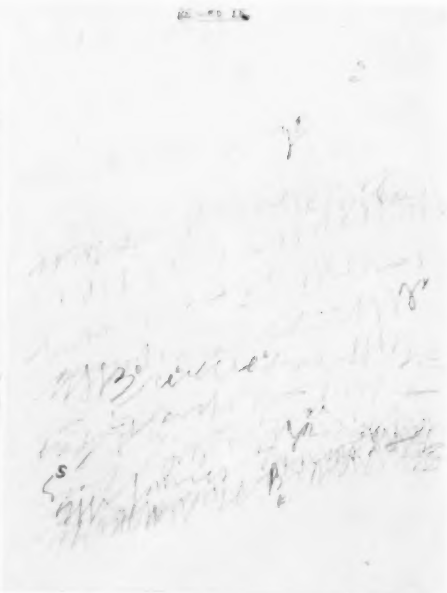
NOTE:—Each record sheet is 8½"x11" typewriter paper

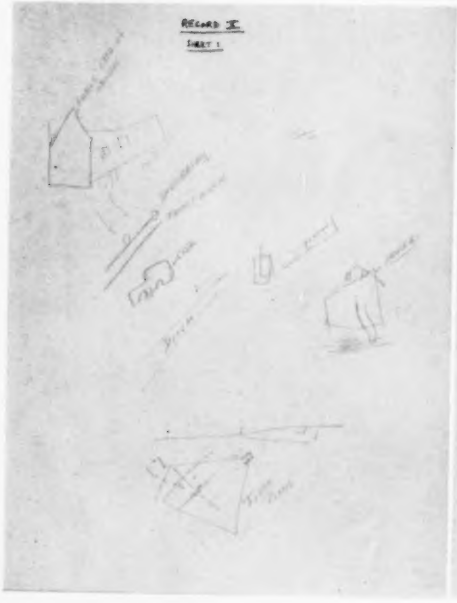

7/x/45
RECORD VII
SHEET 1

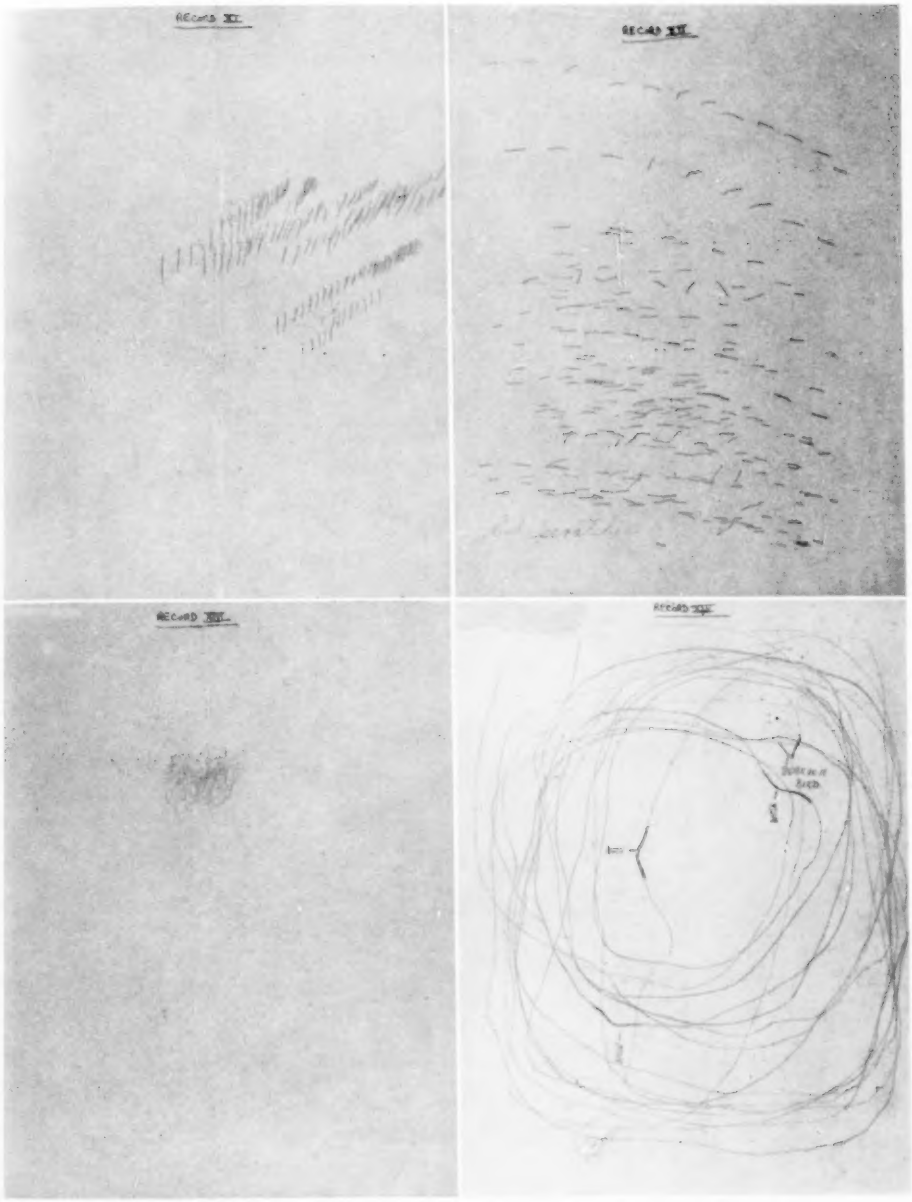

RECORD VII
SHEET 1

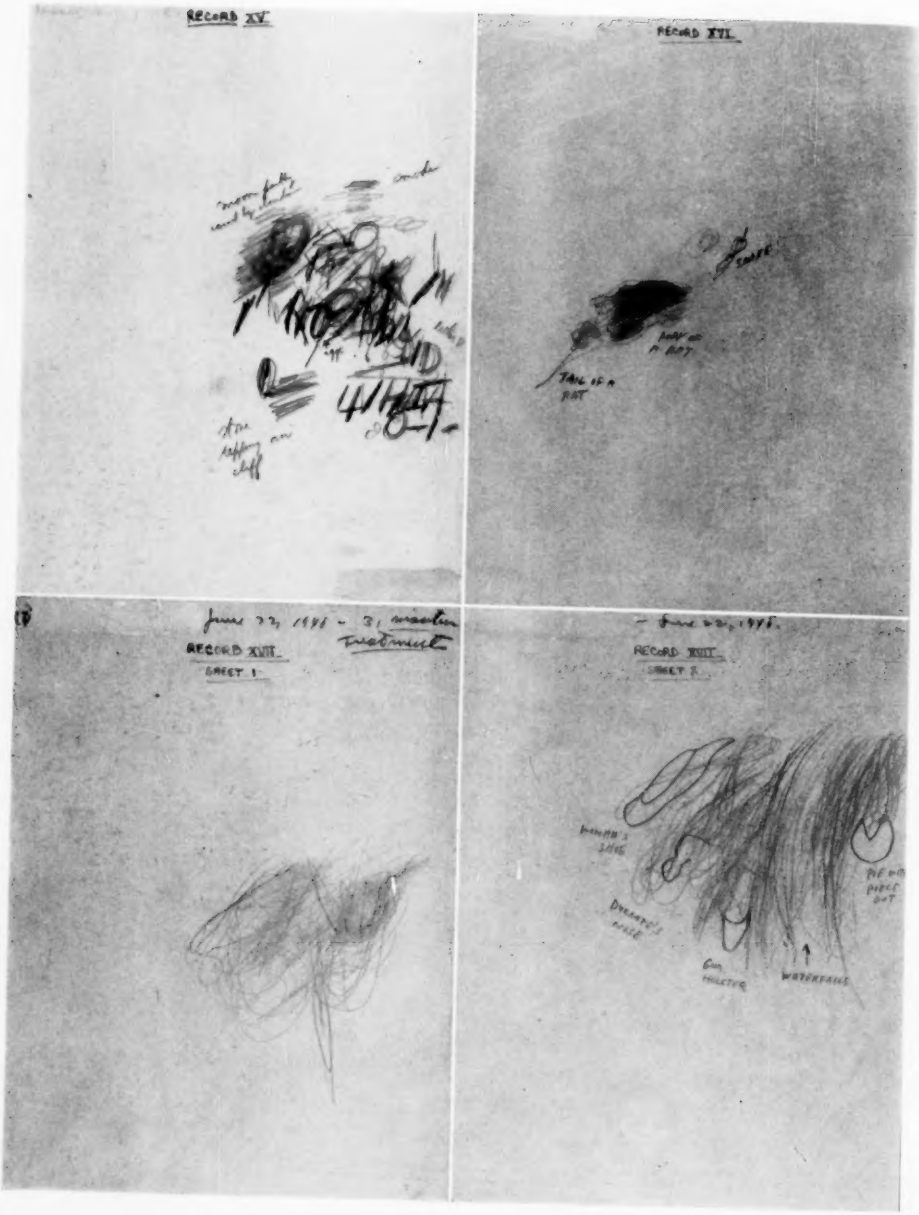

(2)
RECORD VII
SHEET 2

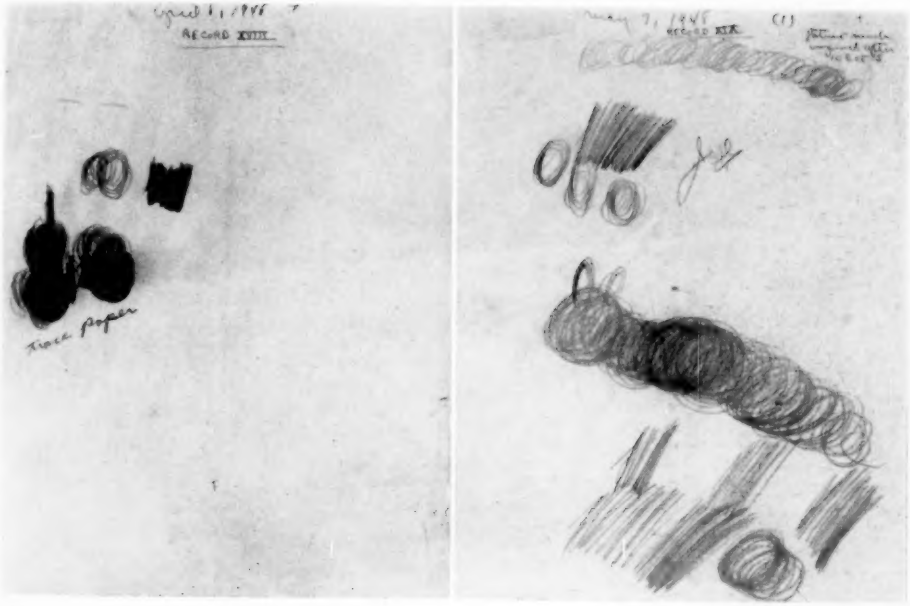


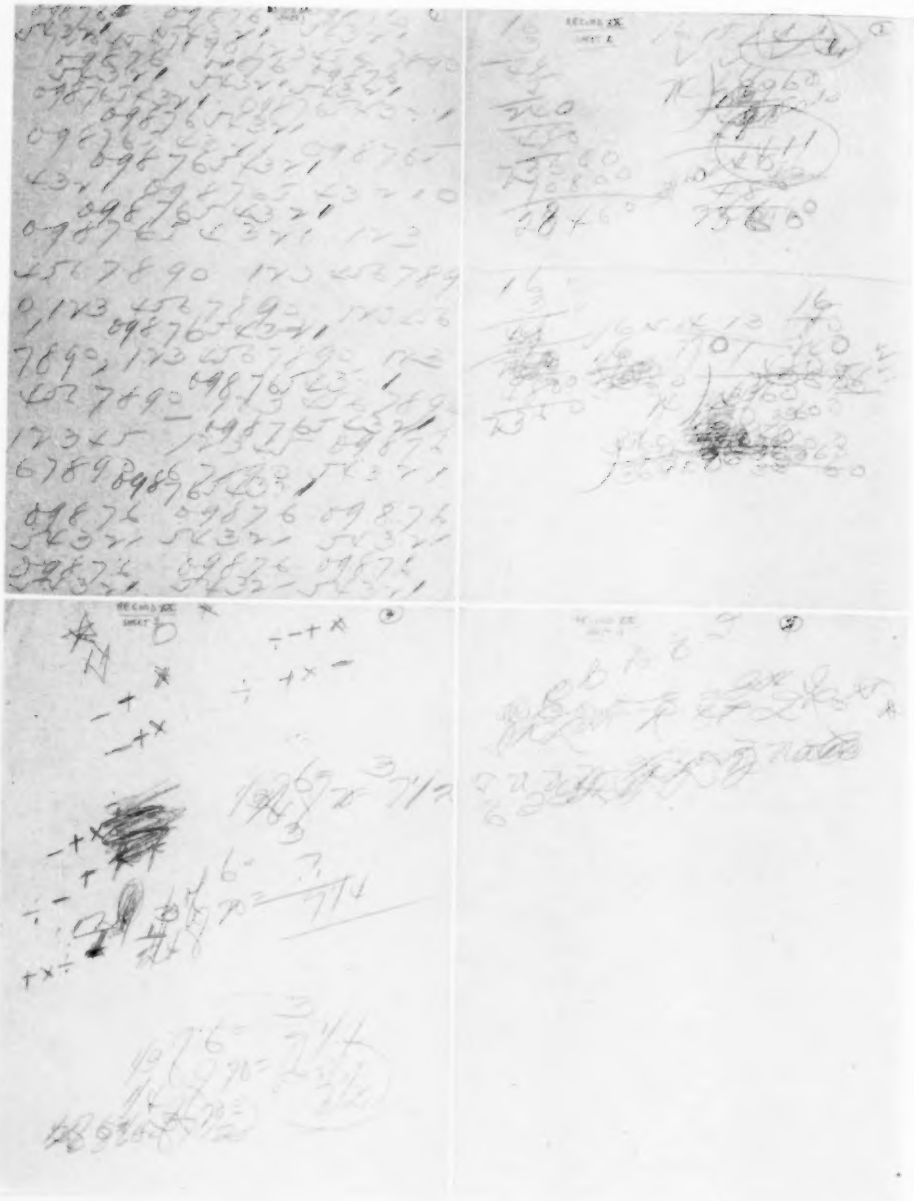





RECORD XI
RECORD XII
RECORD XIII
RECORD XIV




RECORD XVIII
Trace paper



marked anxiety. He was first seen in February 1948. At that time he had feelings of depersonalization in that he would feel his body as being lifeless. In his college classes, he expressed frequent panic reactions which were dynamically related to his repressed homosexuality. He was unable to establish a heterosexual adjustment. His scholastic standing, which had been high, was endangered by his inability to handle his anxiety during examinations and class recitations. Records XV and XVI, taken on February 20 and March 22, 1948, reveal moderately fast movement over a very limited area of the page with heavy pencil pressure in a circular and linear type of marking. It is noted that the field of movement is so restricted that he goes over and over the same area, resulting in high density. There are many distinctly separate productions, especially in Record XV. The content identified, such as "body and tail of a rat without the head," "snake," "a stone tipping over a cliff," "the moon partly covered by clouds," and "smoke" reveal elements of the sexual conflict, as well as the threat that the subject projects into his environment, particularly his feeling of impending doom. There is a slight evidence of the use of defenses such as making and identifying the letters and numbers which perhaps represent his feeble attempt to intellectualize his anxiety. This patient attempts to defend himself clinically by carrying on a full school program with which he feels inadequate to cope.

The patient had several months of supportive psychotherapy without improvement and was then hospitalized. He had a course of insulin shock treatment, beginning in May 1948 and ending in June 1948. Record XVII (Sheets 1 and 2) shows his performance after 31 insulin treatments averaging 10 minutes of coma per treatment.

Comparison with the pre-shock records shows the following characteristics. The movement is moderately fast. The production covers a larger area of the page although still limited in scope. The pencil pressure is lighter, and the field of movement is large enough to diminish the amount of overlapping of the markings. The productions are continuous and more rhythmic. The content identified has a less threatening quality. In describing his reaction to the post-shock test the patient said, "I feel less tense. I used to be afraid of the darkness. Now it's a pleasure." The rec-

ords indicate principally a lessening of anxiety and fear. However, restriction of the movement to a limited area shows that fear of loss of control is still present. Numerous records taken from this patient after each shock treatment showed slow, progressive changes leading up to the final record (XVII).

J. G. is a paranoid schizophrenic who has been hospitalized for several years. Clinically, he evidenced marked anxiety and withdrawal tendencies. On the wards he was uncommunicative. Despite the feeling of the psychiatric staff that little could be accomplished, he received the opportunity for shock therapy. Record XVIII is characterized by a markedly restricted area of performance, heavy pencil pressure, interrupted linear and circular movements, with marked overlapping of the markings. The content shows reliance on a childish behavior pattern in that he made "ovals" and "push and pulls," as is usually done by school children in penmanship exercises. This represents the infantile nature of his defense.

The patient underwent a course of electric shock treatments, after the completion of which he seemed improved clinically. He became something of a favorite of the nurses because of his shy smile and his corncob pipe. Record XIX taken at this time shows that he utilized a larger area of the page. The individual productions were less constricted, the pencil pressure lighter, and there was less overlapping. He still showed the reliance on infantile patterns, interruptions, and constriction. About one month after the completion of shock treatment he again regressed to his previous state of withdrawal.

R. B. came to the hospital suffering from a severe obsessive-compulsive neurosis, featured by an unshakable fixation on numbers and arithmetic. He was constantly involved in calculations. His condition became so severe that he was selected for prefrontal lobotomy. Record XX, Sheet 1 was taken after the operation. After this production, the patient was instructed not to make numbers on the next sheet. He then produced multiplication and division. On being directed not to do these, he produced Sheet 3, which contains arithmetical signs such as plus, minus, times, etc. On Sheet 4, emphasis was placed upon his not producing arithmetic, so he produced the alphabet. This patient's performance throughout was concrete and structured and could not be changed by directions or testing the limits.

Space limitations prevent the inclusion of many other records which illustrate typical findings in specific clinical groups. These will be presented in subsequent communications. Large numbers of records are being collected for most of the well-defined clinical groups. The experimental evidence concerning many of the qualitative and interpretive points will, it is hoped, soon be available.

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REFERENCE

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ANALYSIS OF A HOMOSEXUAL

BY FRANCIS I. REGARDIE, Ph.D.

Perhaps the most clinically difficult and baffling group of cases to handle psychotherapeutically is that relating to alcoholism and homosexuality. It would appear that the secondary gains from the neurotic development are so considerable where libidinous gratification is concerned that in most cases no amount of insight suffices to make any appreciable inroad into the syndrome itself. It is notorious that analysis of any kind is forced to report a high percentage of failure in the treatment of such personality disorders.

The case recorded here is presented for a variety of reasons—the successful termination of treatment being the least significant. First of all, a short dynamic therapy was the decisive factor, appearing worthy of description. Second, the patient produced a remarkable series of dreams which appear to the writer to be classical. At no time in his psychotherapeutic experience extending over a dozen years, has the writer ever previously encountered any dreams which are so dramatic, eloquent in their revelation, or precise in their dynamic implications. Nor has he ever read of any similar series of dreams in the whole range of psychotherapeutic literature which he has consulted. And finally, there is the incidental time factor of successful therapy, encompassed within the bounds of some 40 sessions.

Homosexuality as a sexual deviation is worthy of study under several distinct headings. Judging from the literature involved, perhaps etiological factors could be summarized under three headings: (1) Congenital defects in genital structure. (2) Endocrine insufficiency. (3) Functional maldevelopment.

The case presented here falls within the last category. Therapy was conducted with a view to enhancing the patient's insight into the nature and effect of the environmental influences which pertained to the development of his emotional life. It seems expedient to present the historical material largely as it was elicited, together with the technical processes undertaken to that end. It might be mentioned here that the patient, S. P., was recommended for treatment by a former patient whom the writer had previously treated for homosexuality along rather classical lines, with some degree of success, not quite so complete, however, as that presently achieved with S. P.

The patient was 38 years old, of slight physique, leptosomatic in type, married, and with a history of homosexuality extending back to the age of seven. The immediate motivation for psychotherapy was domestic difficulty. Though married for nine years, his sexual relationships with his wife were of the most meager type. Occasionally there would be a sporadic flare-up of libido, followed by a sexually inactive period, self-contempt and intellectual impotence. Meanwhile, men of a certain type would stimulate him sexually, provoking persistent indulgence in fantasies that would culminate in masturbation. Because of his fear of discovery and social ostracism, he had given up overt homosexual practices. The only sexual channel open to him, therefore, was masturbation. This offended his moral sense so overwhelmingly that he forsook it for long periods, winding up as a completely frustrated, tense individual.

As time proceeded, however, his wife became more and more irritable due to this prolonged period of abstinence, nagged more and more frequently, making his life on occasion thoroughly unpleasant. It was during one of these domestically tense situations that he decided to attempt psychotherapy, knowing full well that if it succeeded a complete reversal of his entire life habits and personality structure was implied. A few months prior to consulting the writer, he had to give up his employment in a large manufacturing plant because of mounting nervous tension together with increasing friction with his fellow-employees.

During the second therapeutic session, S. P. commenced to narrate his family history. He had two younger brothers, one sibling, F., 15 months younger, the other, L., five years younger. He loathed F. with a violent loathing from the date of his arrival, while being quite fond of L. His father, who had been a surgeon, died 24 years ago of a cerebral accident. Apparently his relations with the father were good. "I adored him but didn't see much of him because of his work." Being a busy suburban practitioner, the father's work occupied a great deal of his time so that he didn't see a great deal of his family. He punished his children on occasion, but seemed fair about it so that none of them felt resentment toward him on these grounds. Once in a while when the children would get out of hand, mother would tell father about it when he returned home at night. She would become worked up about their lack of discipline, would develop nervousness, and become weepy and hysterical.

The mother, within the limits of her hysterical temperament, did her best to raise the children well. My patient was her favorite. Knowing it, he used that knowledge to obtain whatever he wanted, and to make her pay more attention to him than to the other children. In any strife with the other siblings, his side was devotedly taken by his mother. His relationship with her seemed something of a game he played, to keep her attentions and affection fixed solely on him. Various situations were instituted solely to foster this dependency. She was something he needed, and for that reason he loved her. "There was no spontaneous feeling to let myself go when I was around her. Didn't realize till she'd gone how much a part of my life she'd become."

The outstanding emotional problem of the early life was his overt hostility to the younger brother, F. On two occasions around two and one-half years of age, he made attempts on F.'s life, first by pushing the baby in his high chair over onto the stove, from which he was rescued just in time; and second, by pushing the baby's perambulator down a flight of stairs. In neither case, fortunately, did the baby come to harm. Until such time as he grew bigger and could fend for himself, F. was continually bullied and dominated by the patient. Initially there was antagonism and resentment over the feeling that F. received the attention that should have been the patient's; he felt he was being pushed aside. This made him feel inferior and insecure. So shaken did this realization leave him, that he instigated a process of withdrawal into himself, mostly as a feeble attempt to bolster up his own sense of worth. However it merely made him more dependent on mother.

The hostilities took the form of "showing F. up" in his mother's eyes, to humiliate and hurt him. This situation has continued ever since over many years, and S. P. has never been able to extricate himself from the conflict. The whole of his life has been influenced by this irrational but powerful hatred. He would deliberately foster emotional scenes in order to complain to mother. His satisfaction was obtained when F. was duly punished. Occasionally, as they grew older and F. grew to be the bigger and stronger of the two, the patient would get himself into a fight with an older boy, enticing the older boy to attack him, knock him down and beat him. F. would not interfere because he knew such an attack was his brother's own fault. But this provided excellent ma-

terial for S. P. to present to mother as a complaint, to win for F. nothing but blame, with love and sympathy for S. P.

The patient's homosexual practices began at a rather early age. He realized when rather young that he was effeminate. Boys were rough and frightened him, so that he preferred playing with girls. One Christmas, he begged for a set of toy dishes such as little girls are given, and when, months afterward, they were broken on some streetcar tracks he was profoundly upset. An older girl flirted with him. Together, they did some little sexual investigation, during which the girl's older brother discovered them, jeered at the boy and threatened to expose them. A little later, S. P. was initiated, as one of a group, into the art of masturbation, by an older boy. Thereafter he frequently masturbated with one of the group, until his guilt-feeling forced him to abstain. From then on, there was a variety of homosexual experiences which continued, on and off, for years. In this instance, guilt intervened until eventually there were no sexual outlets whatsoever but masturbation, and his conscience objected even to this.

The first dream the patient brought to the therapist appeared to be diagnostic and offered a prognosis. "I was on a terrace. It had a wall about 10 feet high, onto a steep incline. The dirt seemed solid at the edge, but wasn't, as water running through from underneath kept washing away the dirt and exposing the logs and sticks that were the foundation. It seemed to be doing it mostly in one place, on the right side, and I kept putting more dirt back on top of the logs to fill up the holes and chinks which the rushing water exposed. I seemed to have a fear of the water rushing underneath."

No attempt was made to interpret any of this material; he was encouraged in free association. Soon he was led away from the dream material to describe tantrums as a child. He "threw" these mostly to get attention at school and at home. He recalled deliberately working himself up to the requisite pitch. It gave him a perverse satisfaction to be the center of attraction, though shortly afterward he would feel guilty and ashamed of himself, especially when some of the school children jeered at him on the the school playground. The tendency to "throw" convulsive tantrums persisted even during his early boarding school days. He described a roommate who was similarly vitriolic, a small but brilliant boy with whom he got on well, generally speaking. But dur-

ing one disagreement, S. P. smashed a window and a door panel, and broke a chair on his friend's head. He was punished and scolded by the school authorities, as a result of which he swore from then on to control himself. It was from this date, that his tensions multiplied to the point where he felt himself continually "wound up too tight" like a clock spring.

A number of dream fragments followed during the next two or three sessions—not too significant, but they aided materially in helping to elicit a more thoroughgoing anamnesis. It was about this time that S. P.'s friend, my former patient, hypnotized him, without my knowledge or permission. The experience, although inducing a comparatively deep hypnotic trance, provoked as a sequel a violent anxiety attack. He had a strong emotional interest in this friend—they had had a homosexual affair about a year previously when they took a vacation together. Of this incident, more at a later date.

S. P. was distinctly disturbed, and his anxiety was allayed only when a superficial interpretation was proffered to him that he had had a homosexual reaction to his friend and that he had attempted to repress it. What transpired from this incident however was fraught with considerable significance, for it suggested a possible technique that could be applied to develop insight into the meaning and purpose of his homosexual trends. It appeared worth while to attempt hypnosis as a means of eliciting hitherto unconscious material. Wolberg's book *Hypnoanalysis* had long since come my way, and had impressed me tremendously. Casual experiments along this line had been attempted, with some degree of success. I might add that I had previously employed hypnosis in the traditional manner, but had discontinued it for obvious reasons, that the basic psychological problem with its unconscious mechanisms was never affected at all by hypnotic suggestion.

For the next couple of sessions, time was consumed in thoroughly conditioning the patient hypnotically. He turned out, it so happened, to be an ideal hypnotic patient, would enter trance upon snap command, and upon awakening would be amnesic about the hypnotic session. A series of experiments was conducted in order to test his suggestibility and the degree and extent of post-hypnotic amnesia.

He was shortly thereafter given a suggestion to have a dream under hypnosis about his feeling in connection with me, with a

view to revealing the nature and type of his transference. The dream that was evoked was highly significant. "Picture of a laboratory. It is all white, with shining instruments. Can see Dr. Regardie with Dad and Dr. G. All have white coats on, and some sort of mirrored eye-piece, stethoscopes. Standing together, talking in low voices while I lie on the operating table, I feel they are talking about me. There is some argument. I hear Dad say, 'Doesn't require operation.' Another says, 'Yes, it must come out.' Regardie says, 'It must come out. But doesn't require operation.' All three come over, and one doctor with a sharp knife in hand bends over me. He stops before he cuts my head open. Regardie reaches out to stop him. Heard Regardie's voice saying something, but then everything grew black, and the scene was gone."

While he was still in the hypnotic state, he was asked to associate freely to the dream. There was considerable hesitancy accompanied by agitation. The patient possessed no insight whatever, and I refrained from any interpretation whatever, relying entirely upon the positive transference that clearly had developed. He regarded me as a friend, someone who would help him to extirpate his homosexual lesion without surgery and without hurting him. No attempt however, was made to explain the transference situation at all at this time. I felt that any premature explanation or interpretation would evoke hostility or defensive measures which would interfere with the eliciting of emotional material.

Shortly afterward, occurred one of the few dreams S. P. recalled having at night. These were not too frequent. But the difficulty of obtaining access to his buried conflicts was later obviated by recourse to hypnosis. It was soon discovered that he could be made to dream of any topic, about any conflict, or any person in his background—dreams that were far more dynamic, direct, and clear than any nocturnal dream.

"About breaking my leg. A woman neighbor was there, very solicitous. I seem small. Suddenly, she grabs me and throws me in the air. I'm frightened. Doctor comes in to set leg. A meal is prepared, but the neighbor keeps forgetting I have a broken leg, broken below right knee. There is a sense of my being important."

Again free association was far from free, even during hypnosis. There was no insight. This was one occasion when I deviated from my predetermined plan of avoiding interpretation. On this occa-

sion, I attempted to impart the tentative notion of an impending sense of punishment, or of castration. This met such great resistance that from this moment on all interpretation was scrupulously avoided. The following series of dreams, together with the patient's free associational material was induced with the intention of giving him insight. As will be seen, this project succeeded to an extraordinary degree, so that before 40 sessions had been concluded, the patient had acquired considerable insight into the significance of his homosexuality, and had begun to function adequately heterosexually.

It occurred to me at this early phase of treatment, on the basis of one of Freud's statements in *The Interpretation of Dreams* that since the dreams of children are relatively uncomplicated, revealing the nature of their conflicts simply and clearly, experimental infantile dreams could be produced in conjunction with hypnotic regression. S. P. was placed under hypnosis and given the direction to count from his present age of 38 backward to 6, with the suggestion that, as he counted, he would regress year by year until he became a little boy of six years. When he had completed his regressive counting audibly, the suggestion was given that he dream on this chronological level about his father. Apparently, since his training had not been intensive enough, no dream formed. But a series of recollections about his childhood affective relationship with father floated to the surface.

"Mother likes daddy very much. She is always very nice to him and so glad when he comes home. I like daddy too. I'd like daddy better if mummy didn't like him so well. Mummy says I must be a good boy and love my daddy. He's a nice man, but I don't love him like I love mummy. She would be very sad if daddy wasn't to come back home any more. If he went away and didn't come back, then I could have mummy all alone. I know mummy needs daddy, so I don't wish too hard for him to go away. I felt bad on wishing daddy to go away. It would make mummy cry, and I don't want her to cry. He's away most of the time anyway. When he comes home, I'm generally in bed."

While still at the regressed level, free associations were encouraged about this set of pictures and feelings. They disclosed his feeling that daddy was a big man, who helped people to get well. The patient had been in his father's office; it was painted all white and shiny, and smelled nice. There was another room where he

"cooked" things, and kept his tools and instruments. There were rows of bottles and medicines. The patient expressed the feeling, "I like him. But don't feel comfortable with him. Don't know him well enough. He treats me just like I was a little boy, kind of if I didn't belong to him. Shows me lots of nice things, and doesn't mind doing it. He's always very busy. Seems to be away a lot of the time."

In order to develop an anamnesis concerning his relations with his parents, another dream was suggested during hypnosis, but without regression, about his relationship with his mother. This time a dream developed. From this moment forward, there was never again any difficulty in producing hypnotic dreams. It became a simple routine to evoke dreams on specific topics by quite simple direct suggestion.

"Can see a large figure dominating everything. She is mother and looks like a madonna. She is tall, big, and at her feet is a child, tugging and pulling at her skirts. He's very small. He runs away and then runs back, tugs again at the skirts attempting to attract attention. Runs away again. He gets knocked down but the large figure bends down and picks him up. Holds him close, pats and fondles him for a few minutes, and then sets him down again. Once more he goes out and more people seem to be standing around. Mingles with them, but he always runs back. The child is increasing in size, still runs back and forth. Runs so fast, I can't see him any more. The large figure holds out her arms and I seem to be falling. Everything becomes blank."

In associating, he realized he was the child with the mother. "The large figure is my ideal as a child of mother and what she stood for—love, protection and security. She was a part of me. When I went away from her and came in contact with other people —to me they seemed insignificant and small, and I resented their intrusion. Seemed as if I could take so much, and then I'd have to assure myself of her devotion once more, to enable me to go forth. I had confidence in myself only so long as I knew she was behind me to back me up. . . . She was all I needed for quite a long time, satisfying all my sexual needs. . . . Girls interested me mainly because they were small replicas of mother, and therefore substitutes for her. . . . Couldn't have sexual escapades with them, because I could not have them with mother. . . . I *won't* have sexual feelings for a madonna, because I know it is wrong. [Agitated.]

. . . I must never have intercourse with any woman because that would in turn destroy mother. . . . My desire for men was merely an expression of my sex desires which were blocked where women were concerned, so I had to resort to myself and then to other men. . . . Couldn't have intercourse with women, right or wrong, because there was no path in that direction. An alternative, though socially forbidden, was the only expression. . . . Homosexuality and masturbation were the only alternatives. Fantasied of young men."

In the next session, a hypnotic dream was suggested showing the relationship of the father to S. P.'s sexual problem.

"Mother is sitting on a three-legged stool. Man—who seemed to be tall, strong, naked, red-colored skin,—is prancing to attack mother with a big stick like a cudgel. I was a little figure who was paralyzed by fear, coupled with excitement or curiosity. Seems like a stage tableau, figures don't move. . . . Have strong desire to drive off, destroy, this attacker. But I feel as though I were unable to move, having terror as well as fascination."

Some interpretation was gently and tentatively offered about the primal scene, but meeting again strong resistance, was withdrawn, the patient was merely asked to associate. "I can see dad standing in the bathroom, shaving, and he's naked. I can see his penis, fascinates me; so big compared to mine."

So much agitation developed at this juncture that the patient came out of hypnosis, very disturbed. He forgot the date of the next session, ringing me up an hour after the session should have ended, telling me he had completely forgotten the appointment. His resistance I regarded as significant, and concluded I was on the right trail.

The following session I re-hypnotized him, had him regress to the age of five and once more got him to associate to the dream, when he began to speak of memories of watching his father shave. On this occasion he was able to verbalize the idea of rivalry with the father for the mother's affection.

Another dream topic was suggested to show the relationship of mother to the homosexual problem:

"Pantomime. Mother is dressed in an old-fashioned, full-type of hoop skirt, falling to the ground. Dad is mounted on some animal. There is some sort of magician there who is able to put up an invisible barrier between dad on the big horse, and mother. This

barrier prevents any sound getting to mother to attract her attention, so mother can't hear him. The magician is very active, though dad tries to get through. The magician is frantically desperate and fatigued from his exertions. Every now and again, dad on horse disappears, when the magician rests and changes into a small replica of a man on horseback. Scene shifts back and forth. Dad appears and disappears, and the magician has to get back and forth. Mother seems never to see the magician, but as long as his incantations work, she never sees dad."

He realizes he is the magician trying to prevent dad from getting to mother. "I wished I could take his place." . . . He thereupon began to realize spontaneously that his hatred of F., his brother, was in reality an affective displacement from his father—F. was a lesser rival of whom he was not afraid to the extent he was of father. . . . "All women were replicas of mother, all men become replicas of dad, with the exception that they weren't rivals for mother, and become important for me as a sexual outlet, mostly in fantasy. I am in love with mother, but I cannot satisfy myself sexually with her so therefore I make use of another avenue. . . . Sex is only possible with those I really hate, and I avoid it with those I really love. If I hate men, then it's all right, for then I cannot destroy anything that doesn't matter. . . . Any punishment I get will not make things worse." Repudiation of women is motivated by the elimination of father as a competitor.

In a subsequent session, he spoke of his sexual feelings toward women in general, and his wife in particular. "In order to have intercourse I have to fight my conscience. In my mind, when I have to fight, my conscience will win. It puts up a resistance which is strong. I say I'll do it, but then I find it's no fun because I have to fight my feelings. In other words, I can't enjoy it because it isn't easy. It's more of a conflict between desire and dislike or distaste. There is always created such a series of conflicting emotions that I have come to escape it altogether."

To elucidate the conflict between desire and super-ego, I hypnotized him, had him regress to five years, and suggested a dream about punishment.

"Can see mummy walking in the woods—faery woods, like a big park. She's walking by a hill in which there is a big cave. A little boy walks beside her dressed like a knight in an iron suit. Mummy looks like a princess, long yellow hair, white dress. As they pass

the cave, a big dragon rushes out, a big red dragon, breathing fire. Mummy screams, and the little boy steps up to protect her. He pulls out sword and runs at the dragon which snaps and bites the sword in two. Boy is now defenseless. He still stands between mummy and dragon but he has nothing left to fight with. Mother sees what happens and puts the little boy behind her and pulls out a cross and holds it up in front of the dragon which, upon seeing it, melts away and disappears."

At first he denied his own obvious interpretation that the dragon was daddy, but soon admitted that "dragon is really daddy sometimes. He brings me candy and toys. I like him then. [Agitated.] Sometimes I think of him as a dragon. He bit my sword in two. I had nothing to fight with. He was going to attack mummy. I was going to kill him. He broke my sword. Mummy saved me." (Agitated.)

His agitation here was so marked that, though still keeping him asleep hypnotically, I brought him up to his normal chronological age, when he associated, "Sword is my prick. Fear, very real, was that dad would destroy it if he found out my real feelings."

In a subsequent session, he was re-hypnotized, and a dream suggested to show the nature of his present problem as it seemed at this stage.

"Am in the country, rather open, very lonely save for a few tall trees. I look up, and realize that the sky overhead is clear, but moving inward from every direction, are black ominous masses of clouds struggling to move in, but these are held back by an area of high pressure surrounding where I stand. The clouds pile higher and blacker. Finally, they rush together and the sky turns black, and there is at once a terrifying display of lightning and thunder, with solid sheets of rain pouring down. I rush to the shelter of the nearest tree, terrified. In a moment or two there is a flash of lightning, and the tree crashes down. I run away and find near by a pillow which I put on my head. The lightning scatters all the feathers to the winds. Have an iron rod in my hand which I thrust into the ground, thinking to use it like a lightning rod, but a bolt hits it and it melts. Panic-stricken, I rush all over seeking shelter. In a clearing near by I see a small shack and hurry into it. It is destroyed by lightning and bursts into flame. I dash out to a pool near by and try to burrow into the mud, covering myself with bullrushes, so that only my head is above water. Then I hear a tre-

mendous peal of thunder. It deafens me. A loud voice peals out of the sky telling me 'to use this' to unlock myself and it says: 'Awake! Awake! You are asleep! Awake!'

"I see an object shining on the ground looking like a huge key, but when I reach out to pick it up it changes to a caduceus, and the snakes snap at me. I recoil fearfully from it. I see the snakes are surrounding a long sharp knife. Suddenly I am enclosed by an invisible barrier, and feel overcome by the heat. On the other side of the barrier is a beautiful lake. I know if I pick up the snake or knife and cut the barrier I can get relief in the water."

During some free association on a later date, he came out of regression, but while still in hypnosis stated, "Yes, doctor, I do remember my fear that he'd cut my penis off. Was terrorized by the thought that in his anger he might cut my prick off in some manner—it would be easy with the razor." (Very agitated.)

In the next session, he advised that following the previous dream he had attempted coitus with his wife, but that he had become impotent. After a short discussion, which yielded little of value, he was hypnotized and asked to dream about this fiasco.

"Seem to see a picture. On a steep mountain side. There is a cave which I want to explore. But I hesitate because hanging right over the opening is a great pack of ice and snow. I'm afraid to go too near and jar this mass of ice loose, for it would come down as an avalanche and bury me. No emotion, just a picture."

Great resistance developed after this dream. It seemed about time to deal with the transference problem, so once more I asked him to dream about the transference situation as of now.

"Seem to be in a kind of space. Can see the outside of a high wall, very beautiful. Like it was made of gold. There is a big gate. As I walk toward it, I see a huge angel standing at the gate —like a very kind person. Big wings, and he beckoned to me to come nearer. Suddenly he seemed to be two people, as though another figure emerged from him—like the devil, with a long forked tail, red skin, horns. As the angel beckoned for me to come forward, the devil chased me with his fork. I ran, always trying to circle back. There was always a devil between. Try as I might, I couldn't get back to the gate. The angel was still beckoning me to come in. Every now and again, the devil, frightening me with his fork, would hurt me and I'd run faster. He seemed to be getting fun out of chasing me, laughing and jumping around."

With this confession of an ambivalent attitude toward me, I began to explain the nature of the transference situation. Without explaining too much, I wanted to get more information regarding the association of the transference situation with the homosexual problem. The reference in the following dream to the man brandishing the knife is incidentally reminiscent of similar details in an earlier dream.

"Seems like a continuation. Find myself being driven by a powerful urge to get through a bushy covered place. I have a bush knife, with which I hack bushes in order to cut a through path. It seems very important to get through. There seems to be a howling and a shrieking going on all around me. I feel something is forcing me to get to an open place. In the center of it is a spiral staircase. It seems to be giving off a warm mellow light. I stumble and run toward it. Suddenly a whole ring of horrible little men appear all around it. [Agitated.] One seems to be a leader, and he steps out brandishing a long sharp knife, telling me to beware. If I so much as put one foot on that staircase I would die. I don't know what to do. I can't go forward, and I'm afraid to go back." (Very agitated and disturbed.)

At first he was adamant in denying either that he feared me on the one hand, or that he had any kind of homosexual feeling about me. His denials were vigorous. No pressure was used in the least, the therapist preferring here to use a nondirective technique in a permissive atmosphere. He was permitted to talk freely in general terms about the foregoing dream, though once again severe resistance began to be manifest in an aversion to discussing homosexuality at all.

In the next session, however, the patient began to talk about a homosexual experience he had had the last summer with one of my other patients who was then undergoing analysis. This experience gave him much emotional relief, yet it shook him through and through, leaving him trembling for some time. He wanted to know what it was all about. With the same hypnotic technique used, he produced the following dream.

"Am walking in the forest, gigantic trees around me, obscured by fog. Knew the trees were there but couldn't see them. Was carrying a lighted candle. After I'd gone a distance I suddenly saw that instead of a candle I was carrying a Xmas tree. Still foggy, but I knew there were a lot of people carrying Xmas trees.

It seemed important that I see, but the fog blinded me. Then I came to a place where fog was thinner, and I saw a man hurrying toward me with a Xmas tree in his arms. When he came toward me I could see him clearly, and he smiled and said 'Hello.' I answered, 'I've been looking for you. Look, I've got a lot of beautiful lights and trimmings to put on our trees.' He smiled , put his tree on the ground and said, 'I've got some trimmings too.' We started to trim each other's tree. I picked up a long string of lights and draped them on his tree and he draped mine. We plugged them in and stood off admiring them. Suddenly mine got a short circuit and burst into flames. I ran screaming around it and rushed into the arms of this man who comforted me."

Some little insight transpired during association and discussion. I still hesitated, refraining from obvious associations and interpretation. He could not explain satisfactorily why he should cause his tree to have a short circuit, and he embarked upon a long, tedious discussion about homosexuality. He appeared hopeless and depressed, feeling that long years of perverse practices had conditioned him against ever developing heterosexuality.

So, therefore, in the next session, I hypnotized him, asking him to dream about the significance of the short circuit.

"I'm at the edge of a huge forest. I suddenly decide to make a little fire with some matches I had stolen, because I wasn't allowed to have matches or play with them. I started a few little twigs and leaves burning. Watching them, a great gust of wind came up and blew my fire out over the forest. I ran after them, trying frantically to stamp them out. The embers kept jumping ahead of me. Suddenly, I heard a terrific roar behind me! The forest was on fire! The fire was high up in the trees. It was racing towards me. I ran as fast as I could to get ahead of it. It kept gaining on me until it was almost over my head. Burning branches and leaves kept falling on me like rain. Couldn't breathe. Roar of the fire was deafening. Suddenly I came to a small lake. The fire was spreading all around the lake. I kept wetting myself with water. I found it more and more difficult to breathe. The heat was horribly intense. I knew I was caught. Suddenly I heard a new sound, I looked up, and what appeared to be a gigantic scythe moving across the tops of the trees, was a knife cutting burning parts off. It kept swinging lower and lower—and was going to cross my head." (Agitated.)

His first associations were to a fire he started as a small boy of six. It had consumed a whole field, and almost burned a house down. His father gave him a rather severe beating when he heard of it.

I brought him back to fire for other associations. "It's fascinating, but it must never be allowed to get out of control." I asked him if this didn't bear some relationship to his feelings about mother. He replied that they were very much alike. "Mother was like a fire. She warmed me, fascinated me. She lit fires in me, fires I had to watch or they'd kill me. . . . I had to suppress my sexual fire for mother because I was afraid dad would punish me for feeling as I did."

At this stage, the therapist embarked intensively into interpretation for the first time, building up logically the theme that behind all S. P.'s homosexual experiences lurked a constant unconscious fantasy about his mother. The reason that his last homosexual experience shook him as powerfully as it did was apparently that the incestuous fantasy was about to enter consciousness—the little homosexual fire might spread into a huge libidinous conflagration which might run away with him, get out of control, and reveal his dangerous secret. In that event, he would lay himself wide open to the sweep of the deadly knife—punishment from father. So, in the homosexual dream, he short-circuited his tree—as a safety precaution, expressing itself symptomatically in the actual experience as leaving him trembling and frightened. The important issue which was hammered home powerfully was that his homosexuality was a hollow shell, a behavioristic reaction-formation which he had built up to buttress his repression of his Oedipal fantasies, and through which, simultaneously, he could secretly express his sexual desires for his mother.

Subsequently, he received a suggestion to dream of the present status of the homosexual problem, after a discussion with me of homosexual transference to me:

"I'm thirsty. I seem to find myself in some sort of desert—sandy place. Sun is burning. On one side, a little distance away, is a grove of trees, very cool looking. On other side, quite a long way off, is a range of mountains. Cool shade of trees beckons to me; I need water. But there is no water there. I know I'll find water in mountains. I'm stumbling across dry waste wanting to go

back, being driven onward by my thirst for water. I can see buzzards and vultures circling above me."

In association he intimated that the grove of trees, though beckoning yet proving waterless, was his homosexuality. The far goal of the mountains was the heterosexual adjustment, which though a difficult route to travel, seemed to be the only safe and sure way. I asked him after association to fantasy about the outcome of this dream. He was still in hypnosis, and was able to imagine freely. He moved forward into the desert, with great difficulty, pain, and suffering. Briefly, just when he was about to give up, he met an old prospector on a donkey. The prospector got off, put my patient on the donkey, and together they journeyed toward the mountains.

In view of these associations, and because in the conscious state he seemed to have arrived at some insight into his problem, all guise of non-directive counseling, and all attempts to ventilate the unconscious conflict were dropped. The therapist resorted to traditional hypnotic suggestion, insisting strongly that S. P. would be able to function satisfactorily in a heterosexual manner with his wife. The therapist felt that in this way old behavior patterns could be exploded, and a new conditioning prepare him for the development of others.

An interesting question of theory arose here, in my mind. It is true that by appropriate suggestion conscious activity can be influenced. But the real question is whether any changes occur in the unconscious ideational process. As far as I am aware, experiments have not been attempted to indicate what unconscious changes have beer produced as a sequel to hypnotic suggestion for the alteration of conscious behavior patterns. For this reason, therefore, at the next session, when the patient informed me that he had begun to function heterosexually with his wife in a satisfactory manner, I hypnotized him in routine fashion, suggesting he dream about his receptivity to my previous suggestions for heterosexual activity.

"M. and I were downtown shopping. We came to a beautiful building, a very modern department store. We went in, and found it full of wonderful things. All the latest, modern objects that glittered. We wandered through the store, exclaiming over the beauty of this, the extraordinary shape of that. Then we came to a wonderful chromium-plated moving stairway which rose right up

in the middle without any appearance of support. M. laughed. We ran over and got on. It was just like flying. We looked out over all this merchandise and lovely colors in the store. Then we were on the second floor; and it was even more wonderful than the first—more color, and all the objects around seemed more glittering—clothing, draperies, blankets, rugs—all in beautiful patterns, soft to feel. After wandering through these for a while, found another moving staircase. This one had neon or some sort of lighting inside the railing. Stair treads were transparent. We got on this one, and seemed to be very happy. M. squealed with delight over its beauty. There was a sign, 'To the roof garden.' We got on. Once in a while we seemed just floating or flying. Suddenly we were on the roof; it was night, and the stars were brilliant. I noticed leaning up against the wall an enormous sky rocket. I pointed it out to M. and said, 'Let's light the fuse.' She said, 'Let's!' I took a match and lit the fuse. It went off with a terrific whizzing. It spiralled up with a beautiful golden arc. It burst, with several successions of different colored stars. It was a beautiful sight. Then we heard a cheering sound, and on looking over the parapet, we saw thousands of people laughing and cheering at us. Apparently they had been entertained and had enjoyed the spectacle of the rocket bursting over their heads. We waved. Just then a soft white cloud floated along, wrapped us up in it, and I seemed to just drift away."

His own free associations, as well as my own interpretation, pointed in the direction of a successful adjustment to his internal conflicts, with the establishment of a heterosexual life in marriage. There had been absolutely no unconscious opposition or hostility to my suggestions. The whole cycle of dream activity had produced insight and developed a state of "readiness" for the next step—the hypnotic reconditioning. It is very interesting to realize that whereas in former dreams dangerous situations surrounded his goal of the staircase, in this dream he appears to reach the staircase—now moving—with his wife. Together they ascend, and even fly. Moreover, while his homosexual trends had always hitherto occasioned conflict and perturbation over the prospect of social ostracism, in the present dream, he indicates the utter disappearance of ostracism. In fact, there is a thoroughgoing

reversal—his sexual activities meet with the approbation of society. Now a crowd of people cheer, and are entertained by, his performance. Social adjustment is fully indicated.

From this moment forward, S. P. appeared able to function rather well sexually. From time to time, a minor spat would develop with his wife. She would irritate him occasionally. He would develop a minor anxiety episode in the event that she evinced any aggressive sexual attitudes. However, as we worked through this problem, and as he dealt with it in an adult, present-day manner, he was able to cope with her irritations, eliminate the doubts as to his adult adjustments, and resume normal sexual functioning.

As the situation now stands, the patient has been placed on a fractional basis. He returns for consultations at monthly intervals. To date, the sexual, domestic and social adjustment continues in a highly satisfactory manner. His dreams corroborate the progress assumed in everyday life. The final dream of this series was elicited hypnotically in the office when he reported following a long absence. During this latter period of fractional treatment, temperamentally deep changes in structure and function were in evidence. Homosexual fantasies no longer occurred, nor did men "intrigue" him as they passed him on the street. His wife's occasional sexual aggressiveness did not provoke anxiety. And his whole set of social contacts and his general social intercourse were improving.

"M. and I seemed to be in quite a large sail boat, rather like a Spanish galleon, on a beautiful day. The ocean was blue, with little whitecaps sparkling in the sun. We seemed to be sailing towards an island. Suddenly I decided to get out of my seat and go to the stern of the ship. I wanted to climb the mast at the top of which I could see a lookout affair. So I shouted to M. to come, and we both ran to the mast, climbed up the rigging, and went up and up to this little crow's nest. The view was beautiful. The mast had a pleasant rocking motion, though the ship was at rest. The sun was warm. We sat there, our arms about each other. The sun began to set, and produced the most gorgeous colors. Suddenly it was gone—and it was dark. We seemed to be approaching a town or a village. Lights all sparkling on the water. As we

came to it through the dark, we heard music. We saw a band playing on the dock. We scrambled down the mast and stepped off the ship. The band seemed to be welcoming us. As soon as we landed, it marched away with both of us following into the darkness."

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EDITORIAL COMMENT

MORE AND MORE ABOUT LESS AND LESS

An old complaint about the narrowing of interest of the medical specialist defines him as a person who gradually comes to learn more and more about less and less. It has come to apply, we think, at least in some degree, to too many among present-day psychiatrists.

This journal, in the past, has given repeated expression to the opinion that it would be well for human health and for the progress of medicine in general if medical men outside our specialty possessed more knowledge of psychiatry and made better use of it. It may be well to point out that the converse is also of importance: It would be well if medical men within our specialty possessed more knowledge of medicine in general and made better use of it. We would particularly emphasize the making better use of it.

It should be remarked at the start that nobody of sense wants busy therapists to spend unnecessary and valuable time in the business of physical examinations. But in this situation of demands on the therapist's time, there may be real danger for the patient. Concurrent illness may develop in any case. And there is misdiagnosis although we may discount the ugly rumors of the case of paresis treated analytically over a period of years.

Thyrotoxicosis is one of the dynamic disorders. It is held by some, indeed, to be the end point of an anxiety disorder. Other endocrine malfunctioning, as diabetes mellitus, is widely attributed primarily to emotional pathology. There are certainly definite, if not too well correlated or understood, alterations in endocrine functioning associated with schizophrenia and other constitutional disorders—not to mention the whole field of psychosomatic medicine. There is no present question of physical medicine for some of these conditions; some of them correct themselves with remission from mental disorder; others are not well enough understood for determination with certainty as to whether physical

measures would be of benefit. There is serious question as to still others. In thyrotoxicosis for instance, even the thoroughly experienced internist and the thoroughly experienced psychiatrist might find themselves in sharp disagreement as to the exact point where somatic therapy is indicated.

If the surgeon, the internist and the general practitioner are prone to overlook or misdiagnose psychiatric conditions, we ourselves are vulnerable to the counter-charge. We can cite cases of early disseminated sclerosis and of cervical arthritis where patients were treated optimistically with psychotherapy for long periods, and for whom the repeated reassurances of the psychotherapists effectively dimmed their victims' later regard for medicine and the medical profession. One may also recall instances of parkinsonism developing concomitantly with psychoneurotic disorders—with the result that the symptoms of parkinsonism were wrongly lumped in with the functional and that proper medical treatment of them was withheld.

The possibility of such contingencies leads to the larger question of orientation. We feel that the competent psychiatrist today must not only be thoroughly convinced of the psychosomatic origin of disease but must radiate that conviction. This is to repudiate both the extreme right and the extreme left. The properly-oriented psychiatrist does not consider that electric shock relieves him of all responsibility for psychotherapy, nor does he think that a patient's receptive attitude toward psychotherapy means that serologic tests are unnecessary. He recognizes that the organic psychoses have symptomatology which may often be alleviated—at least in part—by psychotherapy; and he recognizes that the functional psychoses find expression through an organism—through man with his digestive and eliminatory apparatus, his sense and sex organs, and his infinitely complicated and delicate central and autonomic nervous systems.

The psychosomatic orientation implies something different and something far more inclusive than "neuropsychiatry." This journal once conducted a long and losing fight against this term—official in hospitals of the armed services and other federal government installations—on the grounds that we not only did not want to encourage a bastard neologism, but, more important, that the

word is not properly descriptive of our specialty. There are numerous psychiatrists, of course, and we wish there were more of them, who also are diplomates in neurology; we might note that they are properly both psychiatrists and neurologists, not half of each. But we feel that the specialty of psychiatry itself must and should include enough basic neurology for competence in the examinations and tests prescribed to differentiate neurological from psychiatric conditions and insure neurological consultation when indicated. We feel that it must include enough internal medicine to diagnose readily such psychosis-precipitating conditions as bromide or sulfa-drug poisoning; enough gastro-enterology to distinguish organic pathology from anorexia nervosa; enough dermatology and ophthalmology to distinguish neurodermatosis from fungus infestations and to determine whether a visual disturbance is hysterical or due to an actual lesion.

For this journey back to medical school and a painful pointing out of the obvious, we might ask indulgence—were it not that, as psychiatrists, we are only too well aware that the least considered things are likely to be the obvious. We think the psychiatrist's obligation to be a good doctor is one of those things which are obvious and often are not well considered. We have heard men who were both leaders of our specialty and distinguished ornaments to the profession remark on the many years which had passed since they practised medicine. One would hesitate to take such an expression literally, but the phraseology is not without significance.

A psychiatrist who divorces himself from the main body of medicine places himself in the position of the lay psychotherapist. Now, the usefulness of the lay therapist cannot be denied. Medicine does not have enough psychotherapists to meet the need; many psychologists and others have been adequately trained for psychotherapy; with respect to psychoanalysis, Freud opposed control of practice by the medical profession. This, however, does not place the lay therapist in the position of a doctor; he is undertaking a procedure in which—as in occupational therapy, nursing therapy or social therapy—the co-operation, if not the supervision, of the doctor, should be a requirement. And it should be noted that the prudent and the competent lay therapist does work closely with the doctor. As we see it, there is no need for the medically-trained

practitioner to place himself in any such position. It is true that the demands on his time may be such that he must delegate the business of determining physical status and making appropriate somatic deductions to another physician, but he himself is still in a position to judge of the competency of that procedure and to refer that patient promptly back again with the emergence of any suspicious sign or symptom. The patient himself, comfortably "under doctor's care" cheerfully relinquishes all responsibility when he relates his symptoms to his therapist—*a doctor*.

Parfit observed years ago that it was not only a primary obligation upon the chest man in any given case to exclude tuberculosis unequivocally, but also to determine precisely what ailed his patient. Transposed to our field, we think this calls for careful physical as well as careful psychiatric study and diagnosis. We hold no more brief for the psychiatrist who diagnoses schizophrenia without serologic examination than for the urologist who treats impotence with testosterone without adequate psychiatric examination. We have observed that some of the most successful psychotherapists we know have been general medical practitioners or have had better than cursory acquaintance with general medical practice. We think that is because such a physician keeps at least one hand on the flesh. He is not one to abandon the body and seek too much of the esoteric in psychiatry. In the phrase of which the psychobiologic school is so fond, such a physician sees the "whole patient" and endeavors to treat the "whole patient." But the doctor not well grounded in general medicine cannot expect to see, let alone treat, the "whole patient"; he can, in the first place, have no confidence in his ability to do so; in the second, he cannot expect to gain or keep the confidence of a patient, even of a patient whose disorder is strictly within the limits of his own specialty.

There may be medical or perhaps surgical specialties where the process of learning more and more about less and less is harmless, if not to the actual good of both patient and practitioner. Psychiatry is no such branch of science. We think harm has been done to psychiatry and is still being done to it by some of its best friends—in their at least tacit assumption that psychiatry is synonymous with psychotherapy. The suggestion is not original with us, al-

though we cannot name its proponent, that a useful corrective for this dangerous concept might be to insist on considering the psyche as an organ of the body. This is doubtless bad science and worse semantics; but it would be worth remembering now and then as an antidote for a way of thinking which becomes more nebulous as it narrows, for one can carry the process of more and more about less and less to the point where less and less becomes virtually nothing. The farther we remove ourselves from the broad base of medicine, the nearer we come—like some of our own patients—to the place where mentation can be witless, pointless, and devoted to problems which wouldn't be worth solving if they weren't insoluble anyway.

MORALS MIXED WITH MEDICINE MAKE BAD MEDICINE

Vanity of vanities, saith the preacher, all is vanity. And, even if the sage of *Ecclesiastes* did not have modern psychiatry in mind —it may be good for various maladies which ail us to sit down and ponder once in a while on the precise extent to which his observation may apply.

We ourselves do not hold that all is vanity, that is, not quite all. Psychiatrists, we think, must bear with more than the common lot of human futility and frustration, yet we would not join—even for an instant's therapeutic self-abasement—the great company of not remarkably paranoid, and not unintelligent, though uninformed, folk who hold that psychiatry as a medical specialty has all the scientific validity of palmistry, that its practitioners qualify solely through learning a certain esoteric pig-Latin, and that if a psychiatrist ever cured or even benefited anybody, the result was pure accident. (And this is no jaundiced picture of some of our admirers; one can find those who hold these sour opinions among the neighbors of any mental hospital. Their attenuated influence is in part responsible for the public distrust which has made it difficult for many tax-supported institutions to obtain adequate funds.) But it may be salutary to accept as true in part what we would by no means agree is true of psychiatry as a whole. That is, in the present application, the lack of scientific procedure, the use of much scientific pig-Latin, and the accidental nature of much improvement or cure do apply specifically to one of psychiatry's several major concerns of today.

Our suggestion at the moment is for some general practice, as an orientation exercise, of what Dr. George H. Stevenson calls "armchair psychiatry." The armchair, if one likes, may be accompanied by something tall, wet and frosted, if the something is strictly an accompaniment, for the subject we suggest here for armchair study is the problem of the man who makes things tall, wet and frosted something more than accompaniments. It is, among other things, the age-old problem of the man who, like *Ecclesiastes'* "preacher," concludes that all in life is vanity, and who, unlike the preacher, proceeds to do something alcoholic about it. One may recall, without prejudice as to the etiology of modern practices, the world-famous mathematician who divorced old bar-

ren reason from his bed "and took the daughter of the vine to spouse." That course of action is, alas, no more impossible for scientists than for other men.

We are prone to recall in this connection—we have done so before—the remark of one mental hospital head that he could be hopeful of curing only his alcoholics, while a second held no hope for his alcoholics but felt there was a chance for almost anybody else. We can, of course, subscribe heartily to the conclusions of both. That is, any psychiatrist with reasonable facilities for security and a nursing staff can sober up his alcoholics, treat their vitamin deficiencies and turn them loose when their psychotic episodes subside; and any psychiatrist, after having done so, can look forward confidently to their return, while he can justify hopes of having seen the last of some other patients. If this be scientific method, make the most of it.

There is no desire or disposition here to deny or minimize the vast amount of important scientific research being done on the subject of alcoholism. Since 1937, the Research Council on Problems of Alcohol has been conducting extensive and scientifically-directed investigations into all phases of alcoholism, publishing the immensely valuable *Quarterly Journal of Studies on Alcohol,* and a long list of volumes which have become standard texts for professional use and standard works of information for the layman. Also to be mentioned is the mimeographed publication, *World Research in Alcoholism,* a project a little more than a year old of the Committee on Alcoholism of the Department of Public Welfare of the State of Illinois. Originally distributed to the professional staffs of Illinois state hospitals, this admirable and carefully-annotated bibliography now has a circulation of 1,000 copies in a mailing list which is world wide. Mention of such scientific efforts should also include note of the University of Buffalo School of Medicine Mental Hygiene Clinic, an organization set up for the medical study of the etiology, treatment and prevention of alcoholism, a project emphasizing what we seek to emphasize here—that the problem of the alcoholic is first and foremost medical.

There is plenty of other impressive evidence as to the scope and earnestness of the scientific attack being currently made on alcoholism. We have no adverse criticism to make of it. What we do want to criticize is what we might call the general psychiatric attitude toward it. Wine is a mocker, strong drink is raging—and

so what? Whoever is deceived thereby is not wise—and what concern is it of ours? We might point out that for many of us alcoholism is even legally none of our business. In New York State, for example, an alcoholic without psychosis cannot be treated in a state mental institution. A New York alcoholic can attain the dignity of a psychiatric patient only if he is wealthy enough for treatment at a private institution; if he isn't wealthy enough, he is a plain miscreant, and we jail him. And, of course, the fellow with money enough for other than jail-treatment is a miscreant, too, the law calls him an "inebriate," and he ought to be jailed anyway. That is, alcohol is a moral and legal problem—and why should we worry about it?

Of course we have all read, have all heard somewhere, have all been told, that alcohol is a medical, even a psychiatric, problem. We all know it, in fact; but we sometimes question whether we believe it. We suggest that what we know with our minds, we are not convinced of with our feelings; that like the merely "improved" patient, we are lacking in insight; and that some earnest armchair pondering might contribute greatly to that needed insight.

It might be well, in the first place, to ponder on what we are to ponder about. It seems doubtful if one could get any six psychiatrists, picked strictly at random, to agree on what alcoholism is. Beyond a probable consensus that it involves overindulgence in alcoholic beverages to the point of damage to the drinker or others, we might expect as many definitions as there were psychiatrists, along with theories of etiology ranging from "allergy" to "lack of willpower."

The situation is somewhat analogous to the problem of "general paralysis" before the identification of the Spirochaeta pallida. We had alcoholic paralysis, traumatic paralysis and other varieties. We are not drawing a parallel; we do not anticipate the discovery of a spirochete, infection by which creates abnormal appetite for alcohol; but we do think that there is a certain reminiscent confusion. We might note, for instance, that vitamin deficiency, not alcohol, is now recognized as the precipitating cause of such "alcoholic psychoses" as delirium tremens and alcoholic hallucinosis and that the sole role of alcohol is the production of the precipitating vitamin deficiency. We might note also that dipsomania—which in spite of its name is not a psychiatric dis-

order for public mental institution treatment—is variously considered to be a result of psychoneurosis, manic-depressive disorder, epilepsy or other conventional mental derangement. And we might recall that Korsakoff's psychosis is, by no means, exclusively alcoholic.

Also to be considered here, is the alcoholism resorted to by persons who are already mental sufferers. To oversimplify, there is the psychoneurotic who drinks to dull his anxiety or sense of guilt, or to overcome inhibitions not possessed by "normal" persons. There is the manic-depressive who drinks to combat his depression or heighten his elation, the schizophrenic who drinks from fear. There are vast numbers of non-psychotic alcoholics who are presumed to drink for reasons of latent homosexuality or because of paranoid components in their make-ups—and their existence may be verified by any bartender. There is also the alcoholic psychopath, who may be presumed to get drunk because he likes to get drunk. We all know that he is deranged mentally, but we can't treat him psychiatrically unless he develops a conventional psychosis—and we don't know yet how to treat him in any event.

All this is to say that alcoholism is a medical problem; and it might be a good idea if we learned to feel, as well as know, that it is a medical problem. We might point out also that alcohol, in most of the instances just noted, represents injurious self-medication, or even "suicide by inches," taken much of the time by individuals who do not even recognize the attempt at medication or at suicide. About 30 years ago, Sherwood Anderson in his tale, *Tandy,* caused an alcoholic fruitlessly seeking cure to advance the same hypothesis:

"Drink is not the only thing to which I am addicted," he said. "There is something else. I am a lover and have not found anything to love. That is a big point if you know enough to realize what I mean. It makes my destruction inevitable, you see. There are few who understand that." But assuming this view of alcoholism as suicide, which is fairly general today, to be incorrect, the best alternative suppositions still leave the alcoholism problem in the lap of medicine.

Perhaps some of us have smiled in a superior fashion at the explanation of Alcoholics Anonymous to new members that they are "allergic" to alcohol; but susceptibility to it certainly varies in a manner familiar to allergists, as the skin test devised by John

Nagle, besides other experiments, amply demonstrates. Allergy is, of course, a medical problem, and other explanations, too, lead straight to medicine. Vast numbers of people still hold the belief, which most of us now regard as naïvely simple, that all alcoholism is caused by long-continued use of alcohol, which somehow establishes physical addiction. Doubtless some alcoholism is so caused; if all were so caused, addiction is still a medical problem. Alcoholism was once believed to be inherited, and it is still discussed occasionally from the genetic point of view. We have seen the theory advanced that the strong drink of the North Europeans promoted the survival of the fittest by somehow insuring that weak genes, which presumably escaped death from the table wines of the south, were eliminated from human offspring—thereby accounting for the world empires, the colonizing energy, and the industrial superiority of the peoples of the north. Absurd as this surely is, we know that European firewater appears to have figured in sweeping whole races of primitive peoples from the face of the earth; it is reasonable to suppose that a genetic factor was involved; and one cannot dismiss airily the possibility that alcoholism today presents problems for the worker in medical genetics.

So we come back to our lack of insight into alcoholism as a medical problem. We think this lack has been made more apparent by medicine's notable failure to produce a panacea for alcoholism and by the fact that the most effective current efforts against it are non-medical in conduct and auspices. We are thinking, of course, of Alcoholics Anonymous and of such comparable enterprises as Edward McGoldrick's "Bridge House."

Medical treatment of alcoholism in the past has benefited from non-medical or unorthodox enterprise. The Keeley Cure was once in distinguished medical disrepute (as a proprietary enterprise), but the technique of conditioning a reaction of disgust to alcohol by producing emesis is a widely-employed procedure today. But sobering up, comparatively long confinement with enforced abstinence, and exhortative psychotherapy designed to convince the problem drinker, "You can never, never drink again," have been the mainstays of most modern treatment of alcoholism. It should not be surprising that a group of ex-alcoholics with a positive, dynamic program should capture the popular imagination, win wide popular support and record success after success where such conventional negative treatment has failed.

If the Alcoholics Anonymous movement can inspire sermons, cartoons, news and magazine stories and editorials, including the astonishing feat of capturing a dramative sequence in a newspaper comic strip ("Wash Tubbs"), it has something from which medicine should learn. It also, of course, has a factor, and its most important one, which is not and cannot be medicine's job or a part of medical treatment. That is religion, for Alcoholics Anonymous is group therapy plus religion. The member of Alcoholics Anonymous confesses at the beginning that the problem of alcohol is too much for him, that he cannot handle it without help or with human help and that he needs the help of God. He receives, in a way much more acceptable to many moderns, the sort of help offered by Billy Sunday to those who "hit the sawdust trail," and afforded by many other evangelists in the camp-meeting tents where "the old-time religion is good enough for me."

But the psychiatrist cannot limit his aid to those who accept and experience the personal help of God. Alcoholism also scourges those of no creed and those whose religion is nebulous. As we understand it, McGoldrick at Bridge House has found ways also of reaching these. We are not conversant with the details of his methods; an arousal of conscience is apparently one of the most effective; and conscience is not confined to the formal worshipper. But psychiatry also might have difficulty with Bridge House methods, effective as they appear to be—for Bridge House seems to "cure" two alcoholics out of three. Psychiatry, for instance, might have difficulty with McGoldrick's flat belief that alcoholics should never be told that alcoholism is a disease, for this "gives them a supposedly valid excuse for their excessive drinking. . . . It intensifies an already existing problem because it encourages a person to avoid making an honest appraisal of himself." Few psychiatrists, of course, hold literally that "alcoholism is a disease," but most would agree that it is a manifestation of one—that is, of a personality disorder. The existence of this personality disorder and the alcoholic's acceptance of it often form the basis of psychiatric treatment; that is, a person who believes he is sick may cooperate more willingly than a child who is told he is naughty will accept correction. Aside from reasons of fact and of practical treatment, the psychiatrist will note further objection to McGoldrick's stand in that it appears to intensify guilt and shame as curative methods. If, to oversimplify again, a person tries to

drown out guilt by drinking—which leads to more guilt, which leads to more drinking, and so all around the merry-go-round—making him feel still more guilty would appear doubtful therapy. It would be interesting to know if McGoldrick's successful cases have been selected in some unintentional fashion to exclude those with this particular repetitive mechanism.

One can, regrettably, also find medical people who stress the viewpoint that alcoholism is not a disease. That eminent medicine man, Dr. William (Ole Doc) Brady, tells the public in a syndicated newspaper column: "The greatest stumbling block to the rehabilitation of an alcoholic is the concept that alcoholism is a 'disease.'" The alcoholic drinks, says Dr. Brady, because he has a "deep conviction of personal inferiority" and finds that "this unpleasant frame of mind . . . can be banished by alcohol." He goes on, "Under the influence of sufficient alcohol, the inadequate or inferior person finds, so he thinks, himself more or less socially equal to the superior person by the expedient of using a drug to dull his capacity of appreciation of the true facts." He can be rehabilitated, the good doctor avers, "only by his own determination, once the error of his infantile pattern of conduct is competently explained to him." So the alcoholic has no disease ("other than that caused by the poison alcohol"); he is simply inferior. One would like to see a clinical report from Dr. Brady, with statistical results of competently explaining the "true facts" to these inferiors and thus accomplishing rehabilitation by their "own determination." Pending some such scientific evidence, we cannot regard his theory highly, either as a contribution to the rehabilitation of alcoholics or to mental hygiene. The phenomenon of the superior doctor endeavoring to treat the (constitutionally?) inferior patient is not unknown to psychiatry but is not widely commended. In alcoholism in particular, this and related attitudes are worse than no therapy at all, a point we shall now elaborate.

We think, concerning therapeutic method, that psychiatry can and should learn far more from Alcoholics Anonymous and Bridge House than from any amount of such condescending, moralistic, pseudoscientific rot as we have just been discussing. The methods of these two laymen's organizations have a common factor which is too often lacking in psychiatric, and more particularly, in general medical, treatment of alcoholism. That is, as Jule Eisenbud once observed of another treatment for an entirely different con-

dition, there is "no hostility toward the patient whatsoever." Among the members of Alcoholics Anonymous and at Bridge House, there can be little hostility toward the alcoholic, for those who treat him were themselves once alcoholics. If, at Bridge House, there is intensification of feelings of guilt, the therapist has suffered intensification of his own guilt, too; no holier-than-thou attitude is possible. We consider it much more than doubtful that many medical therapists achieve the total lack of hostility which the ex-alcoholic himself can attain.

We think there is still more to be learned from these non-medical therapists. If alcoholism is, as we believe, in many if not all cases, the result of an underlying personality disorder, what becomes of such personality disorder after treatment by Alcoholics Anonymous or at Bridge House? We assume that religious experience has a profound influence on character structure in many cases; but there must be those in which dependence on God—far preferable as it is to dependence on alcohol—does not have such an effect. And what about such Bridge House patients as are not particularly religious? The "ex-rummy" is traditionally a greatly constricted, difficult and poorly-adjusted person. Personality studies of Alcoholics Anonymous members and former Bridge House inmates might reveal mechanisms of considerable importance in medical psychology.

To recapitulate, we believe that, first of all, we need more insight into the fact that alcoholism in all its various forms presents a psychiatric problem. We believe, second, that we must eliminate punitive or hostile attitudes, even such as are unconscious, from dealings with the alcoholic. If we have reason to think—and there is overwhelming evidence to warrant it—that even the withdrawn schizophrenic can sense unconscious fear, hostility or distrust on the part of the therapist, we have at least equal reason to believe that the alcoholic's perceptions are acute. We cannot expect him to take kindly to the carrying over of the contempt he meets in daily life into the therapeutic situation. The story is told that the great August Forel gave up wine with his meals and became a total abstainer to put himself on an equal footing with his patients—with a great increase thereafter in the efficacy of his treatments. We do not suggest that today's therapist do likewise; far from doing so, we feel that such a performance might, by intensifying moralistic pressures, harm some patients as much as it bene-

fited others; but we do think little good can come from a therapist who feels, even unconsciously, that his alcoholic patients are "drunks," "bums," "lushes," "rummies," or (using the term contemptuously) "just alcoholics." Third, we feel that we should know more about the personalities, about the social adjustments, about the psychodynamics of former alcoholics. In this connection, more psychoanalytic reports and more plain psychiatric and anamnestic reports would also be welcome.

We conceive of alcohol as more protean than Proteus. We think, in treating it, that as we grapple with one problem, we find another; and we are lucky if we understand either. Lewis Carroll once wrote a verse which can describe not only certain results of alcoholism but the reaction of those who treat it:

> He thought he saw a rattlesnake
> That questioned him in Greek:
> He looked again and saw it was
> The middle of next week.
> "The one thing I regret," he said,
> "Is that it cannot speak."

Our present concern is with our scientific attitude—with this nihilistic feeling that the whole problem is incomprehensible, but very much more with our tendency to regard alcohol as a social problem, as a legal problem, and a moral problem, and to assume from the start that it is little or none of our business. Morals and medicine combine to make bad medicine. We have one pressing, and at present insoluble, problem already, through the complication of moral and medical issues in the matter of syphilis. With the modern, penicillin treatment, medicine could wipe syphilis out of existence in America in a few months at the most, if it were not for public resistance by persons who feel, consciously or unconsciously, that the fear of syphilis helps to enforce the moral code.

We have no such treatment possibilities yet in the field of alcoholism; our primary purpose here is not to discuss treatment other than to urge that we give all the encouragement we can to such efforts as those of Alcoholics Anonymous, Bridge House and the National Committee for Education on Problems of Alcoholism, a scientifically-directed, mental hygiene movement of increasing extent and effectiveness. We shall not discuss legal or moral barriers to a more effective program or such definite proposals as

special public institutions to treat alcoholism. We think that, even more important than mental hygiene toward removal of the mote from the public eye would be intensified efforts to remove the beam from our own. What we want, first of all, is a general professional attitude, an increase in professional insight, a change in professional reaction, to permit wider and more intelligent use of the great body of facts which is slowly being accumulated by our research workers. We need, we think, a considerable amount of the introspection which we should be able to acquire by armchair contemplation of ourselves, our reactions, our insights and lack of insights. We doubtless shall arrive first of all at the ancient conclusion that wine is a mocker, strong drink is raging. But we think we may also arrive at a better reply to it than, "So what?"

BOOK REVIEWS

The Energetics of Human Behavior. By G. L. FREEMAN. vii and 344 pages. Cloth. Cornell University Press. Ithaca, N. Y. 1948. Price $3.50.

The Energetics of Human Behavior is an authoritative, sound text on the meaning, characteristics, and functioning of behavior in man. Dr. Freeman, formerly professor of psychology and director of the laboratory of psychophysiology at Northwestern University, is a writer with convictions. He unhesitatingly states that he is disappointed in present-day psychology; and says: "May their [future psychologists'] work have more basic significance than the pebble picking that today clutters our professional journals."

Dr. Freeman concerns himself objectively and scientifically with personality differentiation, behavior disorder and therapy, the homeostatic response curve, the organismic energy system. "Any attempt," he writes, "to neglect the mechanistic base of operations and substitute gross total descriptions of the psychosome can only result in throwing psychology offside the line of scientific development."

The author has spent years in physiological and neurological research, seeking for dynamic implications. "There is nothing mystical," he insists, "in the term 'dynamic' and no reason why its association with organismic biology should imply something extramechanical or essentially psychic." Dr. Freeman credits Titchener with helping to turn his own interest in behavior energetics away from the psychic constructs of Freud and into objective physiological experimentation.

The Energetics of Human Behavior is an outstanding and significant contribution to the field. "It achieves," in the words of J. P. Guilford, psychology department of the University of Southern California, "a rather coherent systematic way of looking at human behavior. . . ." Professor Freeman expands his basic thesis—that all behavior is an attempt to preserve organismic integrity by "homeostatic" restorations of equilibrium—into his summation that objective descriptions of total neuromuscular homeostatis offer independent and direct measures of dynamic behavior wholes which in themselves will ultimately "outfield" the field theories of Gestaltist, psychoanalyst, and other exponents of psychic energetics and phenomenological description.

On Obsession. By ERWIN W. STRAUS, M. D. 92 pages. Paper boards. Nervous and Mental Disease Monographs. New York. 1948. Price $4.00.

Straus' monograph on obsessions is full of half-concealed criticism of Freud, without producing anything new. The author philosophizes a good deal, not seeing the irony in calling Freud a philosopher. Straus is not familiar with the newer psychoanalytic literature on obsessions (Federn, Stengel, Bergler). The booklet is rather ill-tempered, taking cover behind a pseudo-poetic language.

Bodies and Souls. By MAXENE VAN DER MEERSCH. Translated from the French by Eithne Wilkins. 654 pages. Cloth. Pellegrini and Cudahy. New York. 1948. Price $3.75.

As described on the cover, the book is "a dramatic picture of a young doctor's struggle against the men who betray the ideals of their professions and corrupt the medical system by their greed, intrigue and professional jealousies." As it is the French medical system against which Michel Doutreval rebels, the American medical and psychiatric world may read the book with dispassionate interest. The author won the Goncourt prize in 1936 and handles his theme with unusual skill. The book makes fascinating reading.

Modern Pattern for Marriage. By WALTER R. STOKES. 143 pages. Cloth. Rinehart and Co., Inc. New York. 1948. Price $2.25.

Dr. Stokes aims to help young people approaching marriage and others in various phases of marital life. The primary emphasis is on successful sexual adjustment following marriage. He acknowledges that there are other factors which contribute to a successful marriage, but feels that a successful sexual life is the best basis.

The general arrangement of the material follows a sequence which begins with an examination of the personality structure and background possessed by a person approaching marriage. A brief, but clearly defined, discussion of the sexual anatomy and physiology is included, along with diagrams to make the explanation more vivid and meaningful. This discussion is followed by a comprehensive plan for a routine premarital medical service which deals with the procedure and information that the physician is likely to cover in the premarital examination.

The author discusses many important problems which often arise during the early weeks or months of marriage, later during marriage, and concerning child-rising. An excellent chapter is included, devoted to the honeymoon, emphasizing the problem of early sexual adjustment.

This book is well written, is clear and is in simple terms so that the layman will have no difficulty in understanding. It should prove most helpful to the often uninformed person who is contemplating marriage.

Psychiatry, Its Evolution and Present Status. By WILLIAM C. MENNINGER, M. D. 138 pages. Cloth. Cornell University Press. Ithaca, N. Y. 1948. Price $2.00.

This book is clear, concise, and gives a brief résumé of the evolution of psychiatry with a well-written chapter on the understanding of behavior. The relationship of psychiatry to education, industry, penology, and public health is discussed.

It is unfortunate that the author considers state hospitals, which have contributed so much in peace and in war to the mental health and dignity of the common man, a disgrace to our social order. It is well known that it is considered far more difficult for a poor man to gain admission to a private mental institution than for a rich man to enter the Kingdom of Heaven.

This book can be recommended for teachers, nurses, guidance directors, personnel directors, physicians, jurists, and anyone in general who wishes to have a better understanding of human behavior.

Human Knowledge. Its Scope and Limits. By BERTRAND RUSSELL. 524 pages including index. Cloth. Simon and Schuster. New York. 1948. Price $5.00.

Bertrand Russell defines the central purpose of his newest book as an examination of the "relation between individual experience and the genral body of scientific knowledge." This theme has been dominant throughout all the studies of the great English philosopher whose vigor and inspiring temperament have fructified the philosophical thinking of the last four decades.

In the great tradition of the English empirical school, Bertrand Russell is basically an epistemologist utilizing for his studies his profound knowledge of physical and biologic sciences. In crystal-clear language he gives forceful definitions. His philosophy denies skepticism; causality is the fundament of his empiricism; "certainty logic" his conception in contrast to the "probability logic" of other epistemologists. The follower of Russell will not find fundamentally new theories, as this book is more or less a recapitulation, however assembling and including new argumentations and new formulations for his philosophic concept, taken from the progress of science.

Bertrand Russell's lucid method of deduction, his candid style, his sparkling dialectics and inspiring arguments and profound knowledge—as ever rare assets—make the study of the "scope and limits of human knowledge" an unusual intellectual pleasure.

Emotional Security. By MILTON R. SAPIRSTEIN, M. D. 259 pages. Cloth. Crown Publishers. New York. 1948. Price $3.50.

This is a psychoanalytic guide to the problems of adjustment, written with the intelligent layman in mind and with special emphasis on contributions toward more effective living. The theories of the neuroses are reviewed in attempt to find a common denominator rather than to defend any special orientation. Material is drawn from many psychoanalysts, from academic psychologists, anthropologists and physiologists and from recent contributions on human and animal sexual behavior. The author stresses the importance of the character of interpersonal relationships and demonstrates the manner in which inadequate or misused defenses against anxiety bring about neurotic manifestions—which become self-perpetuating into a continuous state of maladaptation. He applies his psychodynamic views of the basic methods of defense against anxiety to a study of disturbances in sexual development and adaptation in our culture, and to the problems of hostility, psychosomatic disorders and war neuroses, and he concludes with a review of the therapeutic value of psychoanalysis. This is a book well worth reading. While one may not agree with all of the analytic reasoning, the author is for the most part very sensible in his expositions.

The Welcome. By HUBERT CREEKMORE. 307 pages. Paper boards. Appleton-Century-Crofts, Inc. New York. 1948. Price $3.00.

This is the story of two men who were close friends in their youth, with a homosexual relationship, at least of the latent type, implied. Don Mason leaves town following his disappointment when his friend Jim marries—and to escape a neurotic mother and the restrictions of life in a small community. Jim's wife proves to be a self-centered and frigid type whose conception of marriage is the attainment of social prestige and material possessions; sexuality and the rearing of children are abhorrent.

The return of Don and his own disappointment in marital life revives Jim's old homosexual conflict; excessive alcoholic drinking only dulls it temporarily; and finally the problem of homosexuality is recognized and creates a tense crisis. Jim becomes acutely disappointed and frustrated when Don marries an aggressive woman.

The book is described as a novel of modern marriage. Does the author wish to imply that modern marriages are unhappy because of personality defects resulting from the cultural patterns of our time? The book ends with Don's marriage and one is left with the author's apparent impression that marriage may resolve his homosexual conflict and that he would make a satisfactory marital adjustment. One doubts that such would be the case without psychiatric treatment.

Anti-Semite and Jew. By JEAN-PAUL SARTRE. Translated by G. J. Becker. 153 pages. Cloth. Shocken Books, Inc. New York. 1948. Price $2.75.

The Jew, like all men, Jean-Paul Sartre holds in his brilliant book, *Anti-Semite and Jew,* is defined by his situation in the world. The author argues—and rightfully—that the *authentic* Jew chooses his Jewish situation; the *unauthentic* Jew flees it. "Anti-Semitism," concludes the French philosopher Sartre, "is not a Jewish problem; it is our problem. . . . Not one [man] will be secure so long as a single Jew—*in France or in the world at large*—can fear for his life."

In *Anti-Semite and Jew,* Sartre paints a powerfully analytical and psychological portrait of the anti-Semite. His insight is deep, his convictions are authentic. He argues legalistically, too: "We should not be afraid to prohibit by basic law statements and acts that tend to bring discredit upon any category" of mankind.

Sartre would have us recall that anti-Semitism is a conception of the Manichaean and primitive world in which hatred for the Jew arises as a great explanatory myth. "It is the expression of a certain ferocious and mystical sense of real property," the philosopher-psychologist indicates.

Psychologically, Sartre points out, the anti-Semite is one who projects his own fears and frustrations on a mythical creation he calls "The Jew." "Anti-Semitism, in short, is fear of the human condition. The Anti-Semite," Sartre insists, "is a man who wishes to be pitiless stone, a furious torrent, a devastating thunderbolt—anything except a man."

Anti-Semite and Jew is unquestionably one of Sartre's most logical publications. It is a dynamic book, provocative, sincere, and influential. It should arouse widespread interest. The versatile contemporary Existentialist has certainly made in *Anti-Semite and Jew* a challenging, psychological contribution to the literature on the Jewish problem. Sartre has expressed in this book some penetrating and analytical views on social psychology.

The Doctor Recommends. By C. O. YOUNG, M. D. 319 pages, with index. Cloth. Wetzel Publishing Company, Inc. Los Angeles. 1946. Price $2.50.

This book offers assorted medical information, rather oddly assorted at times, for the information and instruction of laymen. It includes brief biographical notes on some of the outstanding medical men of the past, and discusses the effect of their discoveries on the practice of medicine. There is also a section on first aid measures. Psychiatric problems are mentioned only in passing.

The Philosopher's Way. By JEAN WAHL. XIV and 334 pages. Cloth. Oxford University Press. New York. 1948. Price $5.00.

The Philosopher's Way, by the brilliant philosopher Jean Wahl, emphasizes not so much the *solutions* of problems in living as the *recognition* of life's problems. The author synthesizes well the long story of man's developing thought, and he comments with perspective and understanding on the values and purposes of philosophy in our day.

To Professor Wahl, philosophy is an adventure in ideas, an endless but exciting quest. We are on the eve, the author holds, of "a tremendous revolution in philosophical thought." But to understand this great change in such thought, we must know the fundamental concepts of substance and causality, of God and the soul of man, of the philosophies of phenomenology and existence, of Gestalt psychology and Whitehead's world-view of modern science. In fine, argues Mr. Wahl, it is important to know the contributions of Plato, Descardes, Kant, Hegel, and the others in the field of thought if we are to interpret best our contemporary world.

The author of *The Philosopher's Way* has produced a good textbook. It examines the great traditional categories of metaphysics: being, quality, existence, becoming, quantity, freedom, causality. To be sure, it is not a book that will be intellectually accessible to readers not already fairly conversant with the tradition of metaphysics in the West; for it makes too many aphoristic references, generally. But the book is suggestive, informative, enlightening, interesting; it is also speculative, even lyrical. To this reviewer's way of thinking, Professor Wahl is quite right in stressing that the path of dialectic, the philosopher's path, is the method by which the perpetual conflict of claims between the subjective and the objective can be resolved.

The Psychoanalytic Reader. Vol. I. Robert Fliess, M. D., editor. 392 pages. Cloth. International Universities Press. New York. 1948. Price $7.50.

The purpose of this anthology is "a compilation of representative papers in psychoanalysis, hitherto uncollected." The trouble with the compilation is that the papers presented are extremely one-sided, reflecting rather the personal predilections of the editor. Paradigmatic is the fact that Karl Abraham's scientifically worthless study "The History of an Impostor" is included, introduced with laudatory remarks. The case, reported by Abraham, was first, not analyzed; second, it assumes a cure through love. Neither fact can be called "representative" of psychoanalysis. It is exactly this extreme one-sidedness of the collection, coupled with the truly forbidding price, which makes the value of the book more than doubtful.

Girl Alive! By FRANCES ULLMANN. 234 pages with illustrations. Cloth. The World Publishing Company. Cleveland, Ohio. Second printing 1948. Price $2.00.

This book will be enjoyed by all 'teen-age girls. It is written by the former editor of *Calling All Girls,* a girls' magazine. The 16 chapters are divided into two sections: "Your Person" and "You and Your World."

Many helpful suggestions are given for the care of the complexion, hair and clothes. One chapter is devoted to "boy meets girl" situations and how to get along with the "men in your life."

The book is understandingly written in an interesting manner and would make an ideal gift for any girl entering, or passing through, the 'teens.

Hôpital Julio de Matos. Etablissement d'assistance aux malades nerveux et mentaux. Pamphlet. Paper.

The "Hôpital Júlio de Matos," named after the distinguished physician Júlio Xavier de Matos (1856-1922), father of the mental hygiene organization and of the psychiatric school in Portugal, is an institution for mental and nervous diseases of a capacity of 1,300. It has been developed gradually since 1942 according to the plans of its patron. Situated in an attractive environment and arranged in a system of 22 pavilions for separation of the different types of mental diseases for sex and age groups, for the neurosurgical service, for a school, etc., it does not offer anything exceptionally unusual. Its medical staff comprises 18 physicians, its nursing staff consists of 20 registered nurses ("*infirmières 1ère class*"), 200 attendants ("*infirmières 2nd class*"), half of them male and half female, and student nurses, attending the nursing school. Occupational and physical therapy, recreational and educational facilities are provided for—in short: The whole set-up of this Portuguese institution, as the descriptive booklet indicates, is a conventional one.

Nutrition in Relation to Cancer. By CHARLES GLEN KING, et al. 140 pages, with many illustrations and bibliography. Paper. Annals of the New York Academy of Sciences. Vol. XLIX, Art. 1, pp. 1-140. 1947. Price $2.00.

The result of a conference on nutrition in relation to cancer is offered in a series of papers. Valuable data gained from experiments in animals and *in vitro* on the effect of nutritional essentials and vitamins (mainly of the Vitamin B complex group) are added to the complex problem on the significance of diet on pathogenesis of cancer. Indispensable details for the worker in the field of cancer research, and informative stimulation for thoughtful physicians are presented in this publication.

This Precious Dust. By RITA KISSIN. 353 pages. Cloth. Ziff-Davis Publishing Company. Chicago. 1949. Price $3.50.

This Precious Dust is the story of Julie, motherless daughter of an orthodox rabbi of pre-Nazi Germany. Julie married a blond Christian, was disowned by the father to whom she was devoted, and was tricked by her husband—now a Nazi—into divorce and emigration alone to America, after which the husband broke his promise to try to join her with their son. American soil is "this precious dust." On American soil, Julie met Peter Dawes, also not of her faith, but possessed of many of her father's qualities; and she married him. Peter developed understanding and put up with her moods and actions until through the work that both of them did for an emotionally disturbed Polish refugee child, their lives became enriched and the bond between them stronger.

From a psychiatric point of view this book gives an insight into the effects of a disturbed environment on children and adults, and it illustrates how much good can be achieved with them by proper sympathy and understanding. The author has a background of work in applied psychology and psychiatry. She is the daughter of a physician and was psychiatric assistant to Dr. W. Beran Wolfe at the Alfred Adler Clinic. She tells an interesting story and presents some concepts about making this a better world by having the great faiths meet on common ground.

The More Perfect Union. By R. M. MACIVER. Cloth. The Macmillan Co. New York. 1948. Price $4.00.

This is a book dealing with the topic of prejudice and discrimination. The author is gravely concerned, because there is no greater danger to a nation than discrimination between different nationalities, races, colors or religions. He clearly points out the types and degrees of discrimination which are most prevalent in politics, education and economics. Practical suggestions are offered; but if the author expects solutions he is being overly optimistic. This book offers little which is new but is a timely review of existing conditions.

Youth in Despair. By RALPH S. BANAY. Cloth. Coward-McCann, Inc. New York. 1948. Price $3.00.

Dr. Banay's book is an outstanding contribution to the understanding of juvenile delinquency. There are excellent chapters dealing with the concept of punishment versus treatment for offenders, environmental factors contributing to delinquency, parents and the environment, environmental factors of the school years and environmental factors within the family. Dr. Banay advocates thorough psychiatric and psychological studies of the personality of delinquents, and feels that punishment serves no purpose, but that offenders should be given psychiatric help. An excellent chapter is devoted to the problem of prevention of delinquency.

The Mirror of Magic. By KURT SELIGMANN. 504 pages. Cloth. Pantheon Books, Inc. New York. 1948. Price $8.50.

The aim of *The Mirror of Magic* by Kurt Seligmann is to present to the general reader a condensed account of the magical ideas and operations in the civilized western world. The volume is especially interesting not alone for its content and text, but also for its attractive format. But, then, the theme of magic always has a fascination for us all: "The fairest thing we can experience," says Albert Einstein, "is the mysterious." Some 250 illustrations grace this book, too; and the scope of its material is enormous—from Mesopotamia, Persia, Egypt, Greece to alchemy, witchcraft, cabala. There is in *The Mirror of Magic* a wealth of illustrations and example which the reader will welcome. As an artist, Mr. Seligmann was concerned with the aesthetic value of magic and its influence upon man's creative imagination.

The author concludes that the relics of ancient peoples tend to indicate that religio-magical beliefs have given a great impulse to artistic activities, a stimulus which outlasted paganism and produced belated flowers in the era of Christianity. *The Mirror of Magic* is a predominantly visual approach to the field. The author accomplishes much in his presentation by beginning with the ancient propitiatory rites of Mesopotamian magic; the growth and development of the magical view is then shown in its successive stages, assimilating Hebrew thought, Greek philosophy, Christian theology, and Arab influence. Kurt Seligmann shows how the magical idea of a unified universe with its manifold correspondences and interrelations found its expression in pictorial motifs, in various symbols, and in the magical arts: astrology, divination, metoposcopy, chiromancy, and physiognomy.

The Wonderful Mrs. Ingram. By HARLAN WARE. 264 pages. Cloth. Whittlesey House. New York and Toronto. 1948. Price $3.00.

In this novel the author attempts to show the effects of an extremely narcissistic woman—who is capable, charming, and ambitious—on her family and friends. She builds her reputation on a "catchy" sentence, "I am never too busy to sew a button on my husband's shirt or to tie a ribbon in my baby's hair." Actually, this is not so, and one can interpret it as a form of defense reaction. It takes a former classmate, a psychiatrist, who spends a week-end at the wonderful Mrs. Ingram's home, to size up, expose and properly straighten out the whole family and the involved friends. Unfortunately, however, the outcome is divorce—but everybody is satisfied. The thought suggests itself that had Mrs. Ingram been treated, perhaps by psychoanalysis, everybody in the family, and among the friends, would have been straightened out—with no divorce—but then, there would not be this thought-provoking and therefore worth-while story!

The Last Defense. By H. J. Heinz and J. Iorgy. xvii and 194 pages. Cloth. Duell, Sloan and Pearce, Inc. New York. 1947. Price $3.00.

In *The Last Defense,* H. J. Heinz and J. Iorgy attempt a psychological study concerning the human urge to aggression, the human forces in polities and economics, the factors in "human liberalism," and the functioning and effectiveness of what they label "humane democracy." The authors feel we have lost our freedom of thought and that until we liberate thought, "we cannot cast off the chains of national antagonisms, racial hatreds, religious intolerances, ideological prejudices."

There are basic causes of racial violence, argue Messrs. Heinz and Iorgy. For one, the urge of self-conservation impels men to behave as if any variation from our characteristics or habits implies a criticism of ourselves, and even provokes violence. "But violence," they add, "always defeats itself." The authors also stress faith and religious values. The stronger our awareness of our conflicting impulses and the more pronounced our control of them, the better we are prepared to withstand the pressures of our outer life. The authors further believe that it is in our spirituality, not our material being, that man's greatest strength lies.

An industrialist and a psychologist have combined forces to write this book about the crises of our times. They strive to solve the problem of peace among mankind. They try to explain how human life is alternately dominated by two diametrically opposing forces: First by the logical, humane, and constructive characteristics we all share, and then by the irrational, cruel, and destructive characteristics we also share. *The Last Defense* shows how, in the opinion of the authors, this dualism in man's nature can be directed toward peace. The book is worth while and is interesting in its emphasis and insistence on the psychological values in living courageously and humanely.

North Face. By Mary Renault. 280 pages. Paper boards. William Morrow and Company. 1948. Price $3.00.

To a small seaside guest house in North Devon, England, Neil Langdon, a frustrated school teacher, resentful and depressed because of the infidelity of his wife and the death of his only child, comes for a rest. There he meets Ellen Shoreland and becomes attracted to her by her youth and her apparent need for protection. Although both have a mutual interest in mountain climbing, sex is the outstanding issue around which the story revolves, and both suffer from sexual inferiorities. The author stresses the role of sexual compatability for a happy marriage, and sexual trial before marriage is apparently advocated to determine compatability. Other personality assets necessary for marital harmony either are not stressed or are relegated to the background. The book is well written but the action is somewhat slow.

The Emotions. Outline of a Theory. By JEAN-PAUL SARTRE. 97 pages. Cloth. Philosophical Library. New York. 1948. Price $2.75.

In this small volume, *The Emotions: Outline of a Theory,* Jean-Paul Sartre attempts to develop a new theory of psychological interpretation. In it, he analyzes the roles which fear, melancholy and anguish play in the life of man, and what in his view is the true reality of conscious life.

The present work reveals another dimension of the intellectual activity of the widely-publicized writer of post-war Europe. In it Sartre reveals himself as a psychologist and metaphysician. *The Emotions* deals with phenomenological psychology; and Sartre tries to show that a psychic fact like emotion, "which is usually held to be a lawless disorder," has a proper signification and cannot be grasped in itself without the *understanding* of this signification.

Sartre's *The Emotions* is a deliberate and sober book in a wide field of psychological investigation. The author seems to be passing from romantic and psychologistic individualism in thought to much social concern. His thoughts, psychological and otherwise, are becoming clarified and more logical.

Historical Sociology. By HARRY ELMER BARNES. 186 pages. Cloth. The Philosophical Library. New York. 1948. Price $3.00.

This book makes an unusual contribution to social theory and techniques, tracing the development of theories of social origins and evolution. The author reviews the work which has been done in historical sociology from ancient times to the present. The merits and defects of past achievement in the field of sociology are presented and a foundation is laid for more extensive and reliable work in the sociological field for the future. Students of sociology may find this book of some value in reviewing the history of their specialty.

Brain and Body Weight in Man: Their Antecedents in Growth and Evolution. A Study in Dynamic Somatometry. By EARL W. COUNT. Paper. Annals of the New York Academy of Sciences. Vol. XLVI, Art. 18, pp. 993-1122. 1947. Price $2.00.

Count studied the changing relation of brain weight to body weight from the direction of physical anthropology. Developmental anatomy, palaeontology and comparative anatomy are the categories of the author's studies with the objective: to formulate the gross-behavior between brain and body weights in man, common traits with other primates and analogies in comparative anatomy. The extensive studies result in a great amount of statistical material and plotted curves.

Contemporary Schools of Psychology. By ROBERT S. WOODWORTH. 279 pages. Cloth. Ronald Press. New York. 1948. Price $3.00.

This is a revision of the 1931 edition. Dr. Woodworth felt a revision was necessary "because important new developments have occurred in nearly every one of the existing schools." He states, "Behaviorism has risen to a more critical scientific level; Gestalt psychology has branched out into new fields; psychoanalysis has changed somewhat in its clinical methods and still more in theory. The 'homonic and holistic' group of schools—are brought together in one chapter. The newer associationists, instead of being considered rather incidentally, are now given a chapter to themselves along with their associationist predecessors."

The book has been completely re-written. The text has been greatly enlarged and its subject matter is more complete. It is now an up-to-date discussion of the present-day schools of psychology. It goes without saying that this text will be found of tremendous importance by all students of psychology.

Readings in the Clinical Method in Psychology. Robert I. Watson, editor. 740 pages with index. Cloth. Harper and Brothers. New York. 1949. Price $4.50.

This is a collection of about fifty interesting papers selected by Dr. Watson from various psychological journals, and including a bibliography of 700 references. The editor intended to provide a volume of general orientation to the work of clinical psychologists, the history of their functions, and applications in diagnosis and treatment. The scope of the book is limited, the editor apologizing for not including such areas as research work being done in clinical psychology. However, he does cover well the various sections attempted: the clinical method; functions of a clinical psychologist; diagnostic methods; and methods of treatment. He has made selections from the writings of various leaders in the field, and has drawn their content together with a chapter at the end of each of the sections. These original contributions are routine reviews, simply identifying the topics without elaboration and serving merely to indicate further readings.

The Management of Men. By R. B. SHUMAN. 208 pages. Cloth. University of Oklahoma Press. Norman, Okla. 1948. Price $3.00.

The author discusses the past, present and future of management. Many suggestions for the training and evaluation of managers are included, along with descriptions of the types who usually make the best managers of men. There are excellent, informative chapters on the nature of man, the nature of organization, the nature of administration, public and private administration, and current problems of administration. Those of us who may be interested in the important problem of personnel management will find this book stimulating, informative and most worthy of careful study.

The Middle of the Journey. By LIONEL TRILLING. 310 pages. Cloth. Viking Press. New York. Macmillan Co. of Canada, Ltd. 1947. Price $3.00.

The Middle of the Journey is the first novel by Lionel Trilling, an associate professor of English at Columbia. It is the story of a period in the life of John Laskell, a professional man of 33 who loses his perspective on life following a serious illness and is withdrawn and insecure. The setting is a small town in New England to which John goes to escape the heat of a New York summer and convalesce from his illness. He seeks a haven with his best friends, a young married couple with modern and liberal views. During the few months of his stay, he is deeply influenced by several emotional experiences: love; a death; and the loss of faith in a friend—a Communist leader who breaks with the party and uses his friendship with John as a means of regaining his personal identity lost for a year during which he had been doing "special secret work."

This novel is mature and may well be generally discussed for its political as well as psychological aspects.

Half a Century in Community Service. By CHARLES S. BERNHEIMER. 146 pages. Cloth. Associated Press. New York. 1948. Price $2.50.

This book deals with the development of social work during the past 50 years from a generalized, unsystematized effort to its present level. It is in the nature of a personal narrative and gives an exposition of the work of the social settlement of five decades ago, particularly in reference to adjustment of the newcomer to the United States, and amelioration of below average social conditions. Dr. Bernheimer is a pioneer and consequently is able to provide insight into the early methods of social work.

This book may be of personal interest to those connected with social work.

The Problem Drinker. By JOSEPH HIRSH. 211 pages. Cloth. Duell, Sloan and Pearce, Inc. New York. 1949. Price $3.00.

The author has written a down-to-earth book about the alcoholic and the problem drinker which avoids sensational nonsense and misguided moralizations. He has concentrated on the facts and the possible solutions of a major problem of society and the individual. The book is thorough, detailed and seems up to date.

Mr. Hirsh carefully surveys the entire subject of alcoholism, facts and fiction concerning it, what alcoholism does, what is being done for the problem drinker, and the role of society and the family. There are also excellent chapters on, "Is Alcoholism to Blame"; "Sick Man or Sinner"; "Recovery Not Cure"; "Alcoholics Anonymous," and "Some Hopeful Signs." The appendix discusses new legislation proposed in various states. This book will prove of great value to students of the problem.

Power and Personality. By HAROLD DWIGHT LASSWELL. 262 pages. Cloth. W. W. Norton & Co., Inc. New York. 1948. Price $3.50.

"Power and personality interact upon each other," argues H. D. Lasswell. In this volume, Dr. Lasswell, who is professor of law at Yale University Law School, has a socio-political objective, the more perfect instrumentation of democratic values. The author also considers the problem of democratic leadership.

But the accent in this brilliant book is on power and the powerful. "Power is an interpersonal situation; those who hold power are empowered." The author concerns himself with the basic question: Is there a political man, a *homo politicus*, a political type? In answer, Professor Lasswell writes comprehensively of the political personality of our time, the varieties of character and personality, and leadership principles.

Dr. Lasswell holds that, since power is decision-making, it figures not only in official institutions but in voluntary associations, including political parties, pressure groups, trade associations, business enterprises, trade unions, and many other organizations.

Power and Personality is based on the author's Thomas W. Salmon Memorial Lecture. It is profound and detailed, interesting in scope and scholarly in pattern. It presents a revaluation of the entire psychological problem in the light of experience and scientific development. Professor Lasswell's book is significant for its definite suggestions concerning the formation of democratic personality, the selection and training of democratic leaders, and the reduction of destructive conflicts in human relationships.

The Madrone Tree. By DAVID DUNCAN. 230 pages. Cloth. The Macmillan Co. New York. 1949. Price $3.00.

With the death of Ivor Jones and the dispelling of the mystery of Bull Woods, the people of Jonesville were freed from the greed for wealth and the power of its mill owner and boss, and from the fanatical Reverend Manley Foxx, Jones' answer to the threat of unionization. Both supported the mystery of Bull Woods, but for different reasons. The moral code of the community was for years based on repression, fostered by Jones and Foxx, who saw to it that the "naked" marked madrone tree symbolized for the people of Jonesville the victory of evil forces, of unrepressed licentiousness. But the closing of the natural channels of expression was too much for some; the madrone tree beckoned and perverted outlet resulted in the form of doings which were finally unravelled by Twist, the psychologist. Selected as a 1949 choice of the Book League of America, *The Madrone Tree* is a suspenseful novel, well oriented psychologically.

In the Name of Humanity. By JOHN LEWIS. 158 pages with six illustrations, bibliography and index. Cloth. Eugenics Publishing Company. New York. 1949. Price $2.00.

The writer's purpose is to interest larger circles in the problem of circumcision and to arouse opinion against it. This theme is a complex one, as it deals with a religious rite as well as with a medical problem. Both subjects are important enough in their implications to demand unbiased discussion. The reviewer, however, feels that the author's personal experiences, mixed with historical aberrations, depress the level of the discussion. One misses an analysis of the adherence to the ceremonial act—as well as an evaluation by scientific statistical methods of the medical problem of circumcision. The book, as it is, is a mere historic contribution dealing with strange rites discussed in an emphatic manner which diminishes the value of any argument.

This problem today definitely deserves an objective, i. e., scientific, discussion and decision. Therefore, Lewis' book might be considered as an attempt to provoke a worth-while debate on the subject.

Third Mental Measurements Yearbook. Oscar Krisen Buros, editor. 1047 pages, with index and bibliographies. Cloth. Rutgers University Press. New Brunswick, N. J. 1949. Price $12.50.

This is the sixth book Oscar Buros has edited in a design to meet a real need of testers in education, industry, psychiatry and psychology through the compilation in a single volume of a fairly complete guide to the location and evaluation of recent tests and books on testing. Over 600 tests are here listed with more than 700 original reviews and sixty-some-odd review excerpts from journals, plus over 3,000 references on the tests' construction, validity and use.

It is a most comprehensive current bibliography of tests, critically reviewed by authorities; it makes possible care and confidence in the selection of tests that will best meet the users' needs from the myriads being published. The reviews have been painstakingly edited to assure that frank illustrations of the test limitations are pointed out along with statements of the values of each. The second section of the book is devoted to over 500 books on measurements, with over seven hundred reviews extracted from the journals. One of Buros' evident goals has been to stimulate critical attitudes; he also makes readily avaiable a wide range of excellent and up-to-date bibliographies of books, providing a basis for discrimination in their study and purchase. Achievement tests, special subjects tests (English, mathematics, languages, social studies, etc.), reading tests, intelligence tests and character and personality tests are covered.

Immortality. By FRANCIS QUOTIDOMINE. 253 pages. Cloth. Issued by the author, through Carey Press Corp. New York City. Portsmouth, Va. 1948. Price $3.50.

Francis Quotidomine, author of the Treatist *Immortality*, would have his readers believe that he is presenting an "All American philosophy bringing to light a new psychology, the fundamental principles of nature, the mystic interpretation of the Bible," and other phases of human existence. It is an ambitious thesis, and one that the author neglects to accomplish sufficiently.

Immortality is nevertheless an inspirational exposition of sections of the Bible and the field of philosophy. As regards the field of psychology, the author attempts analyses of consciousness, instinct, dreams, mental telepathy, mob thought, personality. The author's treatment of the subject-matter is simple and plain, but not clear enough or logical, either. The book lacks consistency and wholeness; it is random in approach; it lacks, too, a basic understanding of psychological and philosophical processes. There are metaphysical implications, some of which border on sense, others hazy and uncertain. The book is somehow mis-named; the label *Immortality* is too imposing, too authoritative and definitive, for such an intellectually slight, unwieldy book.

The Affairs of Dame Rumor. By DAVID J. JACOBSON. 492 pages with index. Cloth. Rinehart & Company, Inc. New York. 1948. Price $5.00.

This is a useful and factual book, designed to refute the general human belief that where there is smoke there is always fire. Here is a historical account of rumors, prejudices, propaganda and allied phenomena. It is, on the whole, good journalism. One may wonder, however, whether the deliberate cultivation of a prejudice, such as anti-Catholicism, or the promotion of a literary forgery such as the *Protocols of Zion* as an instrument of anti-Semitism, are properly to be included in the rumor category. It is also permissible to wonder if the author has not fallen into the opposite error to the one he castigates. Most historians, for instance, will cite data concerning the massacre of St. Bartholomew's Day which Mr. Jacobson appears to believe do not exist. Perhaps this only goes to show that historians are gullible, but on this and other points the author owes us more data.

This general criticism is not intended to imply lack of value in which should prove a very handy reference book.

The Skin of Dreams. By RAYMOND QUENEAU. Translated by H. J. Kaplan. 115 pages. Paper. New Directions. New York. 1948. Price $1.50.

Raymond Queneau, writer of *The Skin of Dreams,* is well known as an author in France where he took his degree at the Sorbonne in philosophy. His book is somewhat autobiographical, and written in a style that relies too much on nuances of Freud and on quasi-Joycean verbal tricks. (Only a translator with a profound knowledge of and ear for French, could have succeeded as H. J. Kaplan has in the translation.) The novel is existentialistic in tone, temperament, and character, which means that it deals with sex impulses of men, and women in relation to men; with intellectual knick-knacks of all kinds; with innuendoes concerning objects basic, fake and folk; with concern for "problems of consciousness," "pulmonous nerves," "shadows of the diaphragm," "collapse of the morale," "physiological abyss," "metaphysical anguish," etc., etc. It is a story of people, of involved dialogue, of existentialistic fury. If you like vagueness without sense, you will express adulation for *The Skin of Dreams;* if you prefer realism with some idealistic logic peppered in, then you may even denounce the book.

Queneau's book is slight in bulk and journalistic in tone. There are in it some penetrating insights, but not enough to make the novel memorable or significant. The story is essentially personalistic and irreligious. It is difficult to translate the actions of the book's characters into universalisms or terms descriptive of the general human situation. It is from the origins of existentialism that *The Skin of Dreams* has its foundation; and the book is therefore made more inconsequential because of its inherent inconsistencies.

The Inner World of Man. By FRANCES G. WICKS. 313 pages. Cloth. Henry Holt & Company. New York. 1948. Price $5.00.

The Inner World of Man is a good introduction to analytical psychology with interpretations based on the Jung theories. Through dreams, fantasies, visions and images, the relationship between the conscious and unconscious is well explained. Mrs. Wicks feels that analysis assists one in keeping contact with the inner world and making certain unconscious material become partially conscious, which she feels contributes to a better adjustment to life's situations.

The use of case histories with a wealth of clinical material demonstrates how patients were aided in gaining insight, which enabled them to help themselves through the guidance of the analyst. Psychological drawings and paintings aid materially in getting a clearer picture of the inner world, its conflicts and strivings.

The Problem Family. An Investigation of Human Relations. By A. S. Neill. 224 pages. Cloth. Hermitage Press, Inc. New York. 1949. Price $2.75.

The introductory chapter of this book is written by Goodwin Watson of Teachers College, Columbia University. He states that he and a group of educators visited Neill's school, "Summerhill," in England. He says, "At other schools we nod approval or express polite criticism. But Summerhill immediately got under our skins. It stirred us up. Some of us were delighted and others were shocked. No one was indifferent. . . . Here is an educator who is clearly on the side of children. . . . He is devoutly for love and against hate; especially is he against hate hypocritically cloaked as virtue. . . . He has demonstrated in practice that self-regulation can work in education. . . . Freedom does not necessarily breed hooligans. I think it is noteworthy that while strict village schools report fist fights every few days, there has been only one instance of a bloody nose in twenty-seven years at Summerhill. It lends some support to Neill's theory that aggression is created by authoritarian discipline and that a generation raised in freedom is essential to world peace."

The Problem Family attempts to smash all orthodox theories and practices in the family-child relationship. It is hard for most of us to believe that entirely uninhibited youngsters are always going to be well-adjusted and good citizens. Praising a child for doing wrong, and ignoring him or giving him a "tip" because he has stolen something are, in most minds, questionable ways of training children. However, one agrees with Mr. Neill that the basis of all conflicts and of most behavior problems is fear. Fear of sex, fear of losing parental love, fear of God are all extremely important.

Even though one cannot agree with everything about which Mr. Neill has written, one admits that this is a very stimulating book, a very different book, a book for parents, educators and psychiatrists.

For the New Mother. By Mildred V. Hardcastle, R. N. Illustrated by Shirley Tattersfield. 163 pages with many drawings and index. Cloth. The John C. Winston Company. Philadelphia-Toronto. 1948. Price $2.00.

The author, herself a mother of twins, gives in her book for the new mother—in a delightful way and with very clever and easy-to-follow instructions—a guide for the bringing up of a baby from the time he comes home from the hospital to the age of one. Special assets are the charming drawings which accompany the text. This is a recommendable book for its sound approach to the problems which every young mother faces in her adjustment to her first baby.

Encyclopedia of Criminology. Edited by Vernon C. Branham, M. D., and Samuel B. Kutash, Ph.D. 525 pages. Cloth. Philosophical Library. New York. 1949. Price $12.00.

In their preface the editors advise that this book has been compiled as a result of numerous requests from laymen and students who "were at a loss as to where they could begin their exploration of the many-faceted aspects of criminality." To accomplish this task the editors have employed 61 contributors, specialists in the fields of psychiatry, psychology, medicine, anthropology, sociology, law, history, penology, religion and philosophy. "Every effort was made to cover all basic concepts and theories that have contributed to the development of criminology as a science. Wherever possible, controversial issues within each topic were dealt with from all acceptable points of view. No attempt was made to pass final judgment on anything."

As one would expect in an encyclopedia, the topics discussed are listed in alphabetical order. The print is fairly small and set up in two columns on each page. The topics are easily located even if one does not use the index which, in this book, is located in the front and does not list page numbers but subdivisions under each topic. Following each article there is a bibliography to suggest further study if desired, since such an encyclopedia cannot possibly be a substitute for original sources.

There is a tremendous amount of information in this book especially for some of us who have not had opportunity or desire to follow all the aspects of criminology. This is, therefore, a "short-cut" or a synopsis of a big subject and should be a popular, and perhaps, necessary book for many.

Adolescence. Its Social Psychology; with an Introduction of Recent Findings from the Fields of Anthropology, Physiology, Medicine, Psychometrics and Sociology. By C. M. Fleming, M. D., Ed. B., Ph. D. 243 pages. Cloth. International Universities Press, Inc., New York. 1949. Price $4.50.

Following the style of most scientific books printed in England this volume is like a textbook—with numerous references following each chapter, with an appendix, with an index to the text and with an index of authors and of references. *Adolescence* is divided into three parts, "The Adolescent at Home," "The Adolescent at School" and "On the Threshold of Maturity." Accordingly the book describes the anthropology, physiology and sociology of the adolescent as pertains to adolescent-parent relationships. Finally, educational and vocational guidance are particularly discussed. In general, this is a discussion based upon numerous scientific articles and books, most of which were written by English authors. It is a good addition to any library.

Therapeutic and Industrial Uses of Music. By DORIS SOIBELMAN. 217 pages. Cloth. Columbia University Press. New York. 1948. Price $3.00.

The sub-title of this book is "A Review of the Literature" and a good share of the book is concerned with just that. The bibliography is extensive, covering 36 pages in itself, and the author appears to have made a thorough, competent investigation of the references with respect to music in the indicated fields. She is described on the jacket of the book as ". . . a research consultant in medical, technical, and social science literature, a graduate of New York University, and she has also studied medicine." In her personal opinions, presented along with factual data, Miss Soibelman makes many well-taken observations. She points out how the idea of music associated as therapy, was expressed in antiquity where it was so much a ritual that it was just a step from music and medicine to music as medicine and that benefits were usually found in people who liked music. She found a paucity of scientifically carried-out experiments in sick people. There were inadequate control groups. She is also concerned with a more precise definition of a goal, clarification of terminology, and an integration of the studies among psychiatrist, clinician and musician.

Many phases of this book make interesting reading, although one must always question the justice done to various authors whose works are quoted very briefly in a short thesis on such an indefinite and as yet unclarified issue.

The Happy Home: A Guide to Family Living. By AGNES E. BENEDICT and ADELE FRANKLIN. With an introduction by Benjamin Spock, M. D. 304 pages, including extensive reading list and index. Cloth. Appleton-Century-Crofts, Inc. New York. 1948. Price $2.75.

This book makes very pleasant reading and will be an excellent guide to family living for inexperienced parents. The authors emphasize that the soil in which to grow healthy children is a family which is built up upon the principles of community life in which each member, even the smallest one, feels his responsibility, his rights as well as his duties toward the community. Children brought up in such an atmosphere will never be problems in their adjustments to the outside world.

The book gives in a humorous way a large variety of everybody's problems as we all have met them either in our childhood or with our own children, and it shows how easily these problems can be solved in the beginning within the frame of understanding in the "family-community."

With its very well-selected reading list and its sound approach to family life, this can be well recommended as a popular handbook for parents.

Gestaltpsychologie. (Gestalt Psychology). By DAVID KATZ. 157 pages With 27 diagramatic illustrations, index and bibliography. Paper. Benno Schwabe & Co. Basel. 1948. Price 8.50 Swiss frcs.

This revised and enlarged edition of the work of Professor Katz, who is now at Stockholm University, was first published in 1943. The second edition, printed in German, has already been translated into Swedish, as well as Spanish, French, Finnish and Italian. The purpose of this most recent survey of Gestalt principles, as stated by the author, is to keep alive the discussion about Gestalt psychology. Most readers, whether students or practising psychologists, will find it a stimulating "refresher course."

As far as identifying himself with a school of psychology, the writer considers himself in agreement with most of the Gestalt school; on the other hand he, like others close to William Stern and the personalistic psychology, definitely believes that the Gestaltist principles cannot be applied to all psychic phenomena.

In 28 short sections, Professor Katz brings before his readers a great many of the explanations as advanced by Max Wertheimer, K. Koffka, W. Köhler and other exponents of Gestalt thinking for problems in the field of perception and sensation, as well as for the phenomenological method, after having outlined the differences between Gestalt psychology and the traditional atomistic-mechanistic psychology (behaviorism included). The author evaluates the constancy hypothesis, and topological psychology with its field theory.

It seems of advantage to clarify that only after the application of the Gestalt principles has been analyzed to a considerable extent, definitions of the concept of Gestalt (which may mean whole, configuration, form, system, although so far no English term has been coined which is an acceptable translation), as expressed by its foremost exponents, are given. In this chapter, perhaps, the field of Gestalt psychology borders very closely on that of epistemology, as far as the interpretation of the meaning of the term Gestalt is concerned.

Problems of reflexology, of motivation, of remembering as well as of animal and of child psychology in the Gestaltist interpretation are examined.

Two examples of the experiments discussed may be mentioned.

The reports of patients whose limbs were amputated showed that the losing of feeling in phantom limbs begins near the amputation. A theory is suggested for the genesis of feeling for the different parts of the body as a maturing child may have it—namely in the opposite direction than when the parts have been removed.

The study of the chemico-dynamic self-regulating power of the organism (unscientifically called "the wisdom of the body"), is evidenced by a

patient whose memory span was not longer than two seconds. This man knew when to eat, how much to eat and even how much to drink! Without remembering his operation he took to bed just as long as required. This is cited to prove that what happens in one part of the organism deeply affects other regions and needs and adjustments.

Professor Katz emphasizes the newer investigations of patterns in the performance of mental tasks and in the transposition of motor patterns. He states that he is unable to go all the way with the Gestaltists in the psychology of thinking, and that the field of the psychology of emotions has not been explored and interpreted by them.

Modern Practice in Psychological Medicine. J. R. Rees, M. D., editor. XII and 488 pages including list of contributors, foreword, appendix and index. Cloth. Paul B. Hoeber, Inc. New York. 1949. Price $10.00.

This book is representative of the present-day stand of psychiatry in Great Britain. The editor and his group of contributors succeed in covering in one volume the diagnostic and therapeutic problems and achievements in the entire field of psychological medicine, a term which is used synonymously for psychiatry. The volume accentuates the integration of psychologic conceptions into general medicine. The Freudian approach prevails throughout; and one feels how uniformly and successfully it is assimilated by the British psychiatric school.

The brilliant chapter on "Health" by Brock Chisholm, the director general of the World Health Organization, deserves special mention. It goes far beyond the unassuming title, and the reviewer regrets that the author was apparently limited in space.

Modern Practice in Psychological Medicine is an excellent handbook to familiarize one with the fundamentals of psychiatry and give an understanding of diagnostic and therapeutic methods in all fields of psychological medicine as conceived in Great Britain. Well-selected case records and references add to the value of this recommendable book.

The Big Secret. By MERLE COLBY. 373 pages. Cloth. The Viking Press. New York. 1949. Price $3.00.

The hero of this novel, David Upstead, gets into no end of trouble with the powers-that-be in Washington. Because of his stubbornness in upholding the need for uninhibited and non-governmental control of scientific research, he eventually wins his point. The tale is something like "Mr. Smith Goes to Washington." Although the book is fiction its author, who has been attached to various Washington bureaus, suggests to the reader that he is well acquainted with that about which he has written.

You Can Change the World. The Christopher Approach. By JAMES KELLER, M. M. xx and 387 pages. Cloth. Longmans, Green and Company. New York. 1948. Price $3.00.

In his book *You Can Change the World,* Father James Keller, M. M., is a religious commentator on the ways of life, its functioning, and the proper administration of one's individual life. Father Keller argues a sound case: In fine, he says that the major problem, the pressing problem facing America (as well as the world, he adds) is materialistic atheism. He argues for "the Christopher approach," the object of which is to develop a sense of personal responsibility and initiative in bringing back to man's consciousness the truths which alone guarantee peace for all mankind.

To be sure, the Christopher movement is under Catholic auspices; but the author holds that "Love of *all* people should be the distinguishing mark of every Christopher." The Christophers (derived from the Greek word, *Christophores, Christ-bearer*) work for the welfare of all men—"of Protestants, Jews, those professing no faith, and those whose background makes them hostile to religion." "In loving solicitude," Father Keller writes, "we are bound to include *all* and exclude *none.*"

On the surface, the viewpoint expressed in *You Can Change the World* is simple and direct. There are essentially but three factors involved: (1) Pray for all; (2) go to all; and (3) teach all. A Christopher spends his time improving, writes Father Keller, not disapproving, because he knows that "it is better to light one candle than to curse the darkness." The movement, in its psychological insistence, emphasizes individual responsibility and individual initiative for the common good of all.

There is in this approach, as outlined in Father Keller's book, a dynamism and strength that are refreshing and even encouraging. Father Keller writes of enduring values, and his approach is genuinely practical. His views are of common-sense quality, however spiritual they are in context. His discussion amounts to a reassurance of faith in human nature. It is a readable, eloquent, quiet book, a treatise based on religious principles but abounding in psychological and pragmatic implications.

Education for a New Japan. By ROBERT KING HALL. XIV and 503 pages. Yale University Press. New Haven, Conn. 1949. Price $6.00.

In his *Education for a New Japan,* Professor Robert King Hall of Teachers College, Columbia University, has written a conclusive, comprehensive, erudite, and authoritative analysis of the important educational experiment now being undertaken in occupied Japan. The author writes brilliantly and with much insight on the vastness, the complexity, and the significance of the problem.

This impressive, well-documented analysis of Japanese occupation is a serious, fundamental statement on a grave issue. The author has had a broad and varied navy experience regarding Japan and the Japanese, during wartime particularly, and from his observations, investigations, studies, and training, he has produced a volume that is unquestionably the most up-to-date, first-hand, and valuable treatise on the subject.

Professor Hall offers a sufficient history of Japanese education, its methodologies, its relation to the state and the various social classes in Japan. He makes definite proposals for its reorganization, including reforming the complicated written language. The author also indicates the problems of implementation.

Professor Hall feels that the Japanese should now accept as fundamental human rights the freedom to learn and the freedom to teach, the freedom to speak and the freedom to write. He advises the Japanese authorities to abandon the traditional centralized and restrictive controls over every phase of Japanese education. The author suggests strongly to the Japanese that they repudiate those of their leaders who do not grant their democratic rights. He would have the Japanese match the legal reforms in their country with positive social reforms. Japanese parents and teachers must rebel, argues Professor Hall, against poor teaching methods and bad textbooks. "The Japanese people must have," he concludes, "continuing faith that over any extended period of time the general mass of the people can know and will select what is best for themselves. This is the indispensable tenet in the democratic philosophy."

Education for a New Japan is perhaps over-detailed and somewhat slanted toward humane idealism. Hall proposes radical changes in the Japanese educational system. The psychology of the people may not allow such alterations without friction and debate, and then only with amendments. But Hall's arguments are well-directed, poignant, sound, and deserve the consideration of all thoughtful educators.

Applied Psychoanalysis. By FELIX DEUTSCH, M. D. 244 pages. Cloth. Grune & Stratton. New York. 1949. Price $3.75.

The author is a distinguished pioneer of psychosomatic medicine. From 1942 to 1947, he acted as chief of the Psychiatry Clinic in Boston, a wartime institution, closed in 1947. The present volume summarizes some of his experiences and techniques in "sector therapy." The title is not a happy one; the author stresses specifically that no connection with classical analysis is intended. The method advocated for neurotic cases in outpatient departments which have neither the time nor the facilities for regular analysis, consists of "goal limited psychotherapy." Specifically, the technique consists of interviews in which "associative anamnesis" is conducted using word stimuli, selected according to the physician's analytic

knowledge and the patient's affectively-conditioned vocabulary. Two cases are presented, only one extensively; the patient had been seen 14 times by the physician. The author is not entirely clear in his statements as to what effects the limited goal. He mentions a variety of factors; *not* the only one which seemingly has some effect. One gets the impression that carefully-selected leading questions stir up superficial, though also repressed, material, which causes so much fright in the decisive and deeper layers that in order to keep the latter from being discovered, "limited" compromises are temporarily made by the patient's unconscious ego. This impression is also fostered by the fact that no distinction is seemingly made by the author between defensive aggression, covering masochistic layers, and real aggression.

All in all, this is an interesting experiment, though not one which gives much hope for becoming a valuable weapon in psychotherapy. The most appealing part of the book is the honesty with which it is stressed that no shortcut of real analysis is intended.

The part of the book dealing with "goal limited adjustment" overshadows in importance a second section, dealing with psychiatry and social welfare.

Patients Have Families. By HENRY B. RICHARDSON, M. D., F. A. C. P. 394 pages. Cloth. The Commonwealth Fund. New York. 1945. Price $3.00.

This book, which deals with illness in families, draws not only from the author's thinking and experience, but also from the co-operative thinking of the "family study" made possible through a grant from the Josiah Macy Jr. Foundation to Cornell University Medical College, Department of Preventive Medicine and Public Health. The research group consisted of the faculties of public health medicine and psychiatry of Cornell University Medical College, New York Hospital, and the personnel of the family care work and educational nursing facilities of the Community Service Society.

In the introduction the author describes his training in the medical profession, and his gradual realization of the patient as a person rather than as "the mitral stenosis in the second bed on the right" in the ward. This realization was aided through contacts with the psychiatrist, social worker and public health nurse.

Patients Have Families is a readable, vivid presentation, given in common language by a doctor of medicine, and should be of interest to the lay reader as well as to professionals whose job it is to deal with people.

The Show of Violence. By FREDERIC WERTHAM, M. D. 270 pages. Cloth. Doubleday & Co., Inc. Garden City, N. Y. 1949. Price $3.00.

Dr. Wertham, author of *Dark Legend,* president of the Association for the Advancement of Psychotherapy and head of the Mental Hygiene Clinic at Queens General Hospital, N. Y., has apparently spent a good deal of his time in the scientific and humane study of behavior leading to the committing of murder. *The Show of Violence* will be widely read because it not only contains provocative information but because it is so extremely interesting that one has a hard time to lay it aside until it is finished. One hears that Hollywood has already obtained the rights on this book but wonders what the motion pictures will do with it. Some persons, especially judges, will not like the apparent animosity which the author directs toward them. He does not exactly give names but the insinuations are quite clear.

The Show of Violence describes in detail several almost unbelievable cases of violence and murder which have been tried in the courts. The author gives his analyses of these cases from the psychiatric viewpoint. He describes actual instances of violence committed by mentally-sick persons who have fared less well, as far as justice is concerned, than have downright malingerers. He criticizes the courts for failing to heed the advice and understanding which psychiatry could have offered. He also condemns the psychiatrists who have expressed fixed opinions and theories after only half-heartedly examining accused persons. "In examining a man charged with murder, the psychiatrist's task is to get the man's real story. That means the outside events of his life and his inner life history which came to catastrophic climax in the murder. The psychiatrist should not merely render an opinion. He should also function, first of all, as a fact finder. . . . The ultra-radical proposal has been made to turn most or all of the offenders over to psychiatry and to abolish the very concepts of responsibility, crime, punishment, and personal guilt. That is not only impracticable, but harmful, for it deflects our attention from the present-day abuses of psychiatric criminology and from the fight against them. Such an abolition of juridical categories would in practice infringe on the safety of society and on the rights of the individual.

"Every murderer tries to justify his deed to himself—'makes a reason' for himself. To think of the mind of murder only in terms of aggressive, destructive, violent, or sadistic impulses with the counterforces of inhibition or conscience only acting as brakes is far too mechanical. In the interplay of mental forces the rationalization is never a mere fiction. The impulse is individual, but the rationalization is social.

"The violence that manifests itself in violent crimes is not the expression of an inborn instinct of aggression and destruction. People like to be nonviolent. It is always other negative factors in personality development and

in the social medium where the growth of the personality takes place that lead to murderous acts of violence. The murderer can never kill without a transformation of values which may come from his innermost mind but is always derived ultimately from social prejudgments and prejudices.

"There is no healing of murder. The real problem is prevention. That requires not only the changing of man but the changing of conditions, the modification not only of individual impulses but of social institutions and rationalizations. The question is not only why one does it but how one justifies it to oneself. The dangers of violence that threaten us come not from the heads of individuals but from social circumstances. Murder is an embolus. The disease lies elsewhere. It is not a matter of episodic violence, but of a continuous violation of the principle of the dignity and value of human life. Actually in our society respect for human life is only a professed theoretical ideal. We must vigorously remove the obstacles that prevent it from becoming a practical reality."

A Miniature Textbook of Feeblemindedness. By LEO KANNER, M. D. Child Care Monographs No. 1. Child Care Publications. New York. 1949. Price $1.25.

This is a brief, stimulating thesis of special value for those who have not kept up with recent publications in the field of mental deficiency. Kanner includes in his monograph a critical historical survey of the field, some recent trends toward reorientation of concepts, and his own suggestions for a modernized classification and outlook. He stresses mainly the need to focus on individual differences among those labeled as feebleminded, offers the term "intellectual inadequacy" to replace "feeblemindedness" or "mental deficiency," and suggests as a more practical scheme of classification than the present the following three categories: 1. Absolute, or pathologically irreversible, feeblemindedness; 2. Relative, or culturally trainable, feeblemindedness; 3. Apparent, or pseudo-feeblemindedness.

To facilitate better understanding and manipulation of the individual patient, Kanner utilizes a "personal profile," consisting of six points of orientation: genetic, cultural, material, physical, educational, and emotional determinants. Illustrative case histories serve to clarify this approach within each of the three categories.

Since Dr. Kanner's 30 pages have been written in a somewhat critical vein and purport to contribute new concepts, a word must be said about the originality of his contribution and the validity of his criticism. Dr. Kanner's ideas and evaluation of present-day concepts already have a wide audience and are accepted by progressive thinkers in the field, such as Doll and Penrose. Thus his proposed classifications can be viewed as restatements of currently-used schema. For example, the absolute feeble-

minded correspond closely to the idiot group; the relative, or culturally trainable, include those now termed morons (for whom administrative policies provide training and boarding-home placement). His third category —apparent or pseudo-feebleminded—is the most valuable insofar as it stresses the importance of cultural setting and emotional factors. However, within such vague, all-inclusive grouping, relatively too much emphasis is placed on specific disabilities and infantile autism as causing faulty diagnosis of mental deficiency.

In this reviewer's opinion Dr. Kanner's criticism is not always too well founded. He deplores the state of bewilderment and lack of clearly-defined concepts, and tends to minimize the contribution of earlier workers. It must be remembered, however, that classification serves a valuable function in the progress of any science, and that only on the foundations built by earlier workers can more clear and practical structures be erected.

To those hoping to find clear-cut description of causes, clinical varieties and treatment expected in anything termed a textbook (even with the modifying adjective "miniature"), it must be stated that the title of this monograph is somewhat misleading.

The Sorcerers. By RUDOLPH KIEVE. 438 pages. Cloth. Houghton Mifflin Co. Boston. 1940. Price $4.00.

The novel describes a sector of Kaiser Wilhelm's Germany from 1910 till the beginning of the short-lived pre-Hitlerian republic. As source material the book is informative.

The author displays all the noble feelings we wish to see in writers: humanitarianism, decency, pity. Unfortunately, these are presented as a treatise, not as the artistic development of characters. As a work of art, *The Sorcerers* is a failure. Without psychological inner motivations, indirectly transmitted, a novel is impossible.

The protagonists of the novel are the Junker Schuck, and the young German Jew, Albert Sulzberger. Both are intended by the author to be "types." Whereas, however, Schuck, despite the author's mistakes in artistic characterization, represents something tangentially real, the Jewish protagonist is not typical at all of the German Jew of times gone by, desperately trying "assimilation" as his way out. Descriptively, for the uninitiated, the most interesting part of the book is the peace-time (1912) exploitation of Polish agricultural workers in Germany; these people were treated like animals by the "master-race," though the name did not exist yet.

CONTRIBUTORS TO THIS ISSUE

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POMPEO MILICI, M. D. Born in New Haven, Conn., in 1903, Dr. Milici was graduated from Yale University in 1925 and from Cornell University Medical School in 1929. After a year's rotating internship and another year in private practice, he joined the New York State hospital

service at Kings Park in 1931. He has been clinical director, and later assistant director (clinical), at that hospital since 1944. Dr. Milici is a fellow of the American Psychiatric Association and is vice-president of the Long Island Psychiatric Society. He has written numerous scientific papers, of which 10 have been published in THE PSYCHIATRIC QUARTERLY. Dr. Milici was married in 1930 and has two sons, aged 17 and 16.

WYMAN GUIN. Mr. Guin describes himself as a "layman interested in the human animal and his prospects." Despite the sexual symbolism which is the subject of his paper in this issue of THE PSYCHIATRIC QUARTERLY, he notes: "Oddly enough, I am not a 'phallic symbolist.'" He remarks, on this subject, that he has always felt that it is due to the simplicity of macroscopic physics that the world is full of holes and things that go into them. Mr. Guin is professional service director of the Lakeside Laboratories, Inc., Milwaukee, Wis.

BEN KARPMAN, M. D. Born in Russia in 1886, Dr. Karpman was educated in America, at Columbia University, the University of North Dakota and the University of Minnesota where he received his medical degree in 1920. He did postgraduate work in Europe, chiefly in psychoanalysis. Dr. Karpman is now chief psychotherapist at St. Elizabeths Hospital, Washington, D. C. He is the author of more than 40 articles on scientific subjects, including several books, and is editor of *The Journal of Clinical Psychopathology.*

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Since 1947 Dr. Berger has been on the staff of Stony Lodge where he is now clinical director. He is at present training in psychoanalysis at the American Institute for Psychoanalysis and doing part-time private practice in New York City. Previous publications include papers on Japanese military psychiatry and a follow-up study of combat-fatigue cases returned to duty. He is a member of the American Psychiatric Association, the American Group Therapy Association and the New York Society for Clinical Psychiatry.

BERNARD C. GLUECK, JR., M. D. Born in Baltimore in 1914, Dr. Glueck is a graduate of Columbia University and of Harvard Medical School, from which he received his medical degree in 1938. After internship in Boston and a residency in Pennsylvania, he went to New York City where he is now in private practice. He is director of Stony Lodge, Ossining-on-Hudson, and attending psychiatrist at Ossining Hospital. He served as a flight surgeon in the United States Army Air Service during World War II and was overseas from 1942 to 1946. He is a diplomate of the American Board of Psychiatry and Neurology. He is the author of a number of scientific publications.

GERALD J. TAYLOR, M. D. Dr. Taylor is medical director of the Bridgeport, Conn., Society for Mental Hygiene and is in private psychiatric practice in Norwalk, Conn. A graduate in medicine of the University of Minnesota in 1941, Dr. Taylor served an internship at Strong Memorial Hospital, Rochester, N. Y., then served four years in the army medical corps, chiefly in the European Theater of Operations. Later, he was a resident psychiatrist at Manhattan State Hospital, then psychiatrist at the adolescent and juvenile courts, New York City, and for the Catholic Charities Guidance Institute, New York City, also engaging in private practice in New York. His societies include the American Psychiatric Association, New York County, Connecticut and Minnesota Medical Societies, and the Society for the Psychological Study of Social Issues.

RAYMOND H. GEHL, M. D. Born in Newark, N. J., in 1917, Dr. Gehl was educated at the University of Michigan, receiving his A. B. degree in June 1937 and his M. D. in June 1940. He served a rotating interneship at the Kings County Hospital from 1940 to 1942 and was resident psychiatrist at the Lyons Veterans Administration Hospital from 1946 to 1948. For a period of six months Dr. Gehl was attached to the Veterans Administration Mental Hygiene Clinic at Newark, N. J. He has been a practising psychiatrist in New Jersey since 1948 and is at present receiving further training at the New York Psychoanalytic Institute. Dr. Gehl is senior staff psychiatrist at the Union County Mental Hygiene Clinic and has been lecturing in the New Jersey Mental Hygiene program. He saw service in the army air corps from 1942 to 1946 as a flight surgeon attaining the rank of major. He is a member of the American Psychiatric Association and of the Aero-Med Association as well as a C. A. A. examiner.

SAMUEL B. KUTASH, Ph.D. Dr. Kutash was born in New York City in 1912, and was educated at the College of the City of New York, Columbia University, and New York University, from which he received his Ph.D.

in 1944. He served as clinical psychologist with the New York City Board of Education from 1935 to 1938, at the Woodbourne Institution for Defective Delinquents from 1942 to 1944, and at Harlem Valley State Hospital from 1944 to 1946. Since 1946 he has been chief clinical psychologist at the Veterans Administration Mental Hygiene Clinic in Newark, N. J. Dr. Kutash served as president of the New Jersey Psychological Association from 1948 to 1949, is a diplomate in clinical psychology of the American Board of Examiners in Professional Psychology, and a fellow in clinical psychology of the American Psychological Association. He has contributed many articles to the psychiatric and psychological literature which have appeared in the *Journal of Clinical Psychology,* THE PSYCHIATRIC QUARTERLY, *The American Journal of Psychotherapy, The Journal of Projective Techniques and Rorschach Research Exchange,* and the *Journal of Clinical Psychopathology* of which he has been an associate editor since 1942. He is co-editor with V. C. Branham, M. D., of the *Encyclopedia of Criminology,* published this year.

FRANCIS I. REGARDIE, Ph.D. Dr. Regardie is a consulting psychologist in Los Angeles. He describes his technique as eclectic. Born in England in 1907, he came to this country in 1921. After studying in Washington, Philadelphia and New York, he received his doctorate in philosophy from Fremont University, Los Angeles. He notes that his own analyses were with Drs. Clegg, Bendit and Robb in London in 1935 and 1936 and with Dr. Nandor Fodor in New York in 1938.

NEWS AND COMMENT

SUBSCRIPTION PRICE OF QUARTERLY INCREASED

Increases in the subscription rate of THE PSYCHIATRIC QUARTERLY and of THE PSYCHIATRIC QUARTERLY SUPPLEMENT will go into effect on January 1, 1950. Effective with the January issue of next year, the annual subscription rate of the QUARTERLY will be $6. That of the SUPPLEMENT, which is issued twice a year, will be $3. Renewals for 1950 of current subscriptions to either publication received by January 1, 1950 will be accepted at the present rate.

The price increases have, of course, been made necessary by greatly increased production costs.

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LETCHWORTH VILLAGE PUBLISHES SPECIAL REPORT

A special annual report to commemorate the fortieth anniversary of the founding of Letchworth Village has been issued by that institution. The report is a substantial volume of 243 pages. It is dedicated to the memory of Charles Sherman Little, M. D., first superintendent of the Village, and to Harry C. Storrs, M. D., present director. Letchworth Village is the largest of New York's six state institutions for mental defectives, and has a world-wide reputation as a model school of its sort.

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DR. BAUMGARTNER TAKES FEDERAL POST

Dr. Leona Baumgartner, pediatrician and former assistant commissioner of the New York City Health Department, has become associate chief of the Children's Bureau, Federal Security Agency, to succeed Dr. Martha M. Eliot. Dr. Eliot has become assistant director-general of the World Health Organization with headquarters in Geneva. Dr. Baumgartner will have special responsibility for the Children's Bureau health services and will administer its annual grants to the states for the extension and improvement of maternal and child health services.

DR. WULF SACHS DIES IN SOUTH AFRICA

Wulf Sachs, M. D., internationally-known psychoanalyst, student and friend of Sigmund Freud, died in South Africa, his home, on June 23 at the age of 56. Born in Russia, Dr. Sachs obtained his medical degree at the Psychoneurological Institute in Leningrad in 1918. He later received

a medical degree from the University of Cologne and did further study in Great Britain. Besides a large number of scientific works, Dr. Sachs wrote *Black Anger* and *Black Hamlet,* books for which he became generally known internationally. He was also editor and publisher of ***The Democrat,*** a South African fortnightly review.